BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1501 Registered No. 67 1501

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ida M. Kennedy

2. DATE AND HOUR OF DEATH: Feb. 11, 1967 | 7:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3606 Gibbons Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-34

D. STREET ADDRESS (If rural, give location): 3606 Gibbons Ave.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 9-5-1873

9. AGE (In years last birthday): 93

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Rumney

14. MOTHER'S MAIDEN NAME: Harriet Wigley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213500908 91

17. INFORMANT: Gilbert F. Kennedy

ADDRESS: 3120 Northway Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Arteriosclerotic Heart Disease

DUE TO (B) congestive failure

DUE TO (C) Hypertensive CVD c failure

DUE TO (D) Senil arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Blindness.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from July 1 1962 to Feb 11 1967, that (I) (we) last saw the deceased alive on Feb 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Donald W. Mintzer M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb 13 1967

23C. PHYSICIAN'S NAME (Type): DONALD W. MINTZER M.D.

23D. ADDRESS: 3009 EVERGREEN BALTO MD 21214

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 2/14/67.

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 14 1967

25B. NAME OF REGISTRAR: Robert E. Tarbyna

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc

ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-65 D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1502 Registered No. 67 1502

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (Berenger) Berenger Zachary T.

2. DATE AND HOUR OF DEATH (5:40) 2/13/67 | 5:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland Gen. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md B. COUNTY ~~XXXXXXXXX~~ Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 7-03

D. STREET ADDRESS (If rural, give location) 812 N Montford Ave

5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 11/19/88 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired

10B. KIND OF BUSINESS OR INDUSTRY Postal Clerk.

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME x John Berenger

14. MOTHER'S MAIDEN NAME x ? Crawford

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 218-36-3261

17. INFORMANT Chart ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION — 3 days

DUE TO

(B) ARTERIO SCLEROSIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2/

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Daniel C. Wilkerson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 2/13/67

23C. PHYSICIAN'S NAME (Type) Daniel C. Wilkerson M.D.

23D. ADDRESS 421 Regester Ave. Balt. 12

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 2/16/67.

24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 14 1967

25B. NAME OF REGISTRAR Robert E. Farber M.D.

25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. ADDRESS Balto. Md. 21214

VS 150-REV. 1/1/65

1 6 7 0 0 0 1 5 0 d

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

30-48-98TN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1503 E.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1503

1. NAME OF DECEASED (Type or Print): JAMES TODD

2. DATE AND HOUR OF DEATH: 2/9/67 | 9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balt
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 511 DELAWARE AVENUE 21204

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 2-26-39
9. AGE (In years last birthday): 27
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): I.B.M. Operator
10B. KIND OF BUSINESS OR INDUSTRY: Supreme Court Bldg.
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~EDWARD M. COLLINS~~ Edwin M. Todd
14. MOTHER'S MAIDEN NAME: EVELYN MAE TODD Dell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: BCH: RECORDS — ADDRESS: 4940 EASTERN AVE. 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gram neg. septicemia — 1wk
DUE TO
(B) Upper GI bleeding — 1mo.
DUE TO
(C) urinary tract infections — 7yrs.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Spino-bulbar poliomyelitis — 7yrs.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 1960 to 2/9 1967, that (I) (we) last saw the deceased alive on 2/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (saw) (did not) view the body after death.

23A. SIGNATURE: Peter J. Rosen M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/9/67
23C. PHYSICIAN'S NAME (Type): DR. PETER ROSEN M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVE. BALTO. MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/14/67
24C. NAME of CEMETERY or CREMATORY: Gracelawn Mem. Cemetery
24D. LOCATION (City, town, or county) (State): New Castle County, Delaware

25A. DATE REC'D BY HEALTH DEPT.: FEB 14 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21
ADDRESS

VS 150-REV. 1/1965

M-525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1504 Registered No. 67 1504

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Nellie G. Monaghan

2. DATE AND HOUR OF DEATH: Feb. 10, 1967 | 2:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): House In The Pines, Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-48

D. STREET ADDRESS (If rural, give location): 520 Walker Ave., Apt. A.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widowed	10/27/1886	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John A. Schaffer	Catherine Breen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-05-9693	D Miss Rose M. Monaghan	(Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Arteriosclerotic Heart disease

DUE TO

(C) Hypertension Diabetes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 12/15/1966 to Feb 9 - 1967, that (I) (~~we~~) last saw the deceased alive on 2/5/1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Manuel Sodaro M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/11/67

23C. PHYSICIAN'S NAME (Type): Manuel Sodaro M.D.

23D. ADDRESS: 4624 York Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/14/1967	Holy Redeemer	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 14 1967	Robert E. Fahrney	H.W. Jenkins & Sons Co.	4905 York

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

B-652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1595 Registered No. 67 1595

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ARTHUR JAMES, BRANCH

2. DATE AND HOUR OF DEATH: Feb. 10, 1967 10 45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md GEN. HOSP. BALTO, Md 21201

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 9-06
D. STREET ADDRESS (If rural, give location): 1618 E. 31st St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 05-27-89
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED-BOOKKEEPER
10B. KIND OF BUSINESS OR INDUSTRY: ACCOUNTING
11. BIRTHPLACE (State or foreign country): VA. (SUFFOLK)
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY BRANCH
14. MOTHER'S MAIDEN NAME: ANNE MAY CRAIG

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES ~~NO~~
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-03-8666
17. INFORMANT: MRS. EVA V. BRANCH ADDRESS: SAME

Dr Kenneth R Koskinen

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ruptured abdomonial aortic aneurysm

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): YES.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/8/67 19 to 2/10 19 67, that (I) (we) last saw the deceased alive on 2/10/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R Koskinen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/10/67

23C. PHYSICIAN'S NAME (Type): KENNETH R. KOSKINEN M.D.
23D. ADDRESS: Md Gen Hosp BALTO., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/13/1967
24C. NAME of CEMETERY or CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 14 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Road Balto. 12, Md.

Robert E. Fahey M.D.

VS 150-REV. 2/66 FEB 14 1967

0 1 5 0 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1506 Registered No. 67 1506

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth H. Tinsley

2. DATE AND HOUR OF DEATH: 2/13/67 | 6:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1501 Dukeland Street

1607

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12/8/81

9. AGE (In years last birthday): 85

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Samuel J. Briggs

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

1B. 334X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — one week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C) Cerebrovascular insufficiency — Months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. old Myocardial infarction

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/6/67 19 to 2/13/67 19, that (I) (we) last saw the deceased alive on 2/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John S. Sergent, M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/13/67

23C. PHYSICIAN'S NAME (Type): John Sergent, M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/16/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county): Arbutus (Baltimore) (State): Md

25A. DATE RECEIVED BY HEALTH DEPT.: FEB 14 1967

25B. NAME OF REGISTRAR: Robert E. Fabiano

25C. FUNERAL DIRECTOR: Joseph L. Russ ADDRESS: 2222 W. Northern

VS 150-REV. 1/1/65

1967000 1508

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-60 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1507 Registered No. 67 1507

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GRAY, BERTHA M.

2. DATE AND HOUR OF DEATH: 3 P.M 2-8-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-02

D. STREET ADDRESS (If rural, give location): 1708 PRESBURY STREET

46

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	C	Widowed	2.5.94	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Dennis Bastic

14. MOTHER'S MAIDEN NAME: BOSTICK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: BEULAH HAMIEL ADDRESS: 2931 PRESSTMAN

MEDICAL CERTIFICATION

18. 33 / X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBRAL HOEMORRHAGE

DUE TO

(B) HYPERTENSIVE ARTERIOSCLEROTIC VASCULAR DISEASE. — 9 days

DUE TO

(C) URAEMIA; PNEMONIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-1-1967 to 2-8-1967, that (I) (we) last saw the deceased alive on 2-8-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Biswanath Pillai M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-8-1967

23C. PHYSICIAN'S NAME (Type): V. BISWANATH PILLAI M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/11/67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State): Westport (Baltimore) Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 14 1967

25B. NAME OF REGISTRAR: Robert E. Fabian

25C. FUNERAL DIRECTOR: Joseph L. Russ

ADDRESS: 2222 W. North Ave. Baltimore, Md.

VS 150-REV. 1/1/65

1 6 7 0 0 0 1 5 0 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-3010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1508 Registered No. 67 1508

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Willie Lee Scott

2. DATE AND HOUR OF DEATH: Feb. 13, 1967 1:46 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa. B. COUNTY: V-33
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Chester
D. STREET ADDRESS (If rural, give location): 106 Penn Street

5. SEX: M
6. RACE: col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10/28/28
9. AGE (In years last birthday): 38
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Scott
14. MOTHER'S MAIDEN NAME: Emma Watts

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Yes USA 1945-1947
16. SOCIAL SECURITY NO.: 194-20-5249
17. INFORMANT: Records- US PHS Hospital, Balto, Md. ADDRESS:

MEDICAL CERTIFICATION

1B. 201 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Gastric hemorrhage — 1 day
DUE TO
(B) Chronic steroid therapy — 2 + mos
DUE TO
(C) Hodgkin's disease — 1½ yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 9 1966, to Feb. 13 1967, that (I) (we) last saw the deceased alive on Feb. 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Morton R Axelrod M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/14/67
23C. PHYSICIAN'S NAME (Type): Morton R. Axelrod, Surgeon (R) M.D.
23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. (BURIAL) CREMATION, REMOVAL (Specify):
24B. DATE: 2-18-67
24C. NAME of CEMETERY or CREMATORY: Haven Mem. Park
24D. LOCATION (City, town, or county) (State): Fairtonville Del. Co.

25A. DATE REC'D BY HEALTH DEPT.: FEB 14 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: W. M. Jones 1226 W 3rd St Chester Pa

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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VS 150-REV. 1/1/65

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C-616

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1509 Registered No. 67 1509

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARRY CRAWFORD

2. DATE AND HOUR PRONOUNCED DEAD: February 11, 1967 9:40 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 838 N. Carey Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 838 N. Carey Street

00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	widowed	7/15/1882	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor	self-emp.	Virginia	

13. FATHER'S NAME: Addison Crawford

14. MOTHER'S MAIDEN NAME: Winnie Bland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 230-09-0726

17. INFORMANT: Eugenia Smith — ADDRESS: Hospitania Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

422.1

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/11/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	2/15/1967	Mt Auburn Cem	Balto.	Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 15 1967	Robert E. Fasbayma	Earl Gilmore	1827 W. North Ave

VS 151-REV. 1/1/65

1967009511

BIRTH NO. 67 1510

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1510

1. NAME OF DECEASED (Type or Print): Percy Whitehead

2. DATE AND HOUR OF DEATH: 2.11.67 9:04 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital BALTIMORE, MD 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE 20-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 21229
D. STREET ADDRESS (If rural, give location): 232 S. MT OLIVET LANE

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 9.19.19
9. AGE (In years last birthday): 47
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: AUGUSTUS Whitehead
14. MOTHER'S MAIDEN NAME: LUCY HESPETH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sarah Whitehead ADDRESS: 232 S. Mt Olivet Lane

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 1577 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pancreatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6mos

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-16-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: PANCREATIC CARCINOMA
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1.5.67 19 to 2.11.67 19, that (I) (we) last saw the deceased alive on 2.11.67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert M. Winslow M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2:11.67
23C. PHYSICIAN'S NAME (Type): Robert M. Winslow M.D.
23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/15/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: Earl Gilmore ADDRESS: 1827 W. North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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VS 150-REV. 1/1/65

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1511

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1511

1. NAME OF DECEASED (Type or Print): Franklin C Hermock

2. DATE AND HOUR OF DEATH: 2/14/67 | 11 35 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 2714 Gwynnmore Ave Gwynnmore

5. SEX: MALE

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: 06-01-06

9. AGE (In years last birthday): 60

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10B. KIND OF BUSINESS OR INDUSTRY: Board of Education

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugo Chermock

14. MOTHER'S MAIDEN NAME: Barbara Merhaut

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 202124462

17. INFORMANT: Self ADDRESS

MEDICAL CERTIFICATION

1B. 430.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Staph Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 30 days

DUE TO

(B) abscess ?

DUE TO

(C) Acute Bacterial Endocarditis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/3/67 19 to 2/14/67 19, that (I) (we) last saw the deceased alive on 2/14/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert M Bu M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/14/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

24B. DATE: 2-18-67

24C. NAME of CEMETERY or CREMATORY: London Park

24D. LOCATION (City, town, or county) (State): BALTIMORE, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Geo. L. Schwab Funeral Home ADDRESS: Francis H. Miller 2101 Frederick Ave.

VS 150-REV. 1/1/65

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67 1512

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 1512

Registered No.

1. NAME OF DECEASED (Type or Print): Benjamin Lamke

2. DATE AND HOUR PRONOUNCED DEAD: 2/14/67 | 5:05 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 12 S. Robinson St.

5. SEX	6. RACE	7. MARITAL STATUS (NEVER MARRIED, MARRIED, WIDOWED, DIVORCED) (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	Hours	If Under 24 Hrs. Min.
male	white	Married	1/11/1898	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nail Operator	Bethlehem Steel	Baltimore, Maryland	USA

13. FATHER'S NAME: Steven Lamke

14. MOTHER'S MAIDEN NAME: Victoria ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW1	217-01-2818	Mrs. Frances Lamke	12 S. Robinson Street

MEDICAL CERTIFICATION

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/14/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/17/'67	Baltimore National Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 15 1967	Robert E. Farley, M.D.	John A. Moran, Inc.	3000 E. Baltimore St.

VS 151-REV. 1/1/65

1967000151 4

0-416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1513 Registered No. 67 1513

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): OLIVER IRMA M

2. DATE AND HOUR OF DEATH: 2/13/67 2:25 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLES GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1538

D. STREET ADDRESS (If rural, give location): 3411 Liberty Heights Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	C	Married	7/27/24	42	7 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ELEVATOR OPERATOR	JOHN HOPKINS HOSPITAL	MARYLAND	USA

13. FATHER'S NAME: HANDY JANEY

14. MOTHER'S MAIDEN NAME: NORA B Brooks

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Louise Brooks ADDRESS: 3310 St. Ambrose St.

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARCINOMA OF BREAST with bone Metastasis

DUE TO

(B)

DUE TO

(C) Metastasis To liver and Brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-10 1967 to 2-13 1967, that (I) (we) last saw the deceased alive on 2-13-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Montoya M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/13/67

23C. PHYSICIAN'S NAME (Type): Alejandro Montoya M.D.

23D. ADDRESS: North Charles General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-18-67	Arbutus Mem. Pk.	Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967

25B. NAME OF REGISTRAR: Robert E. Faherma

25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 848 N Calhoun St

VS 150-REV. 1/1/65

1967 0 0 1 5 1 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-426

BIRTH NO. 67 1514

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1514

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RAYMOND G. WILKERSON

2. DATE AND HOUR PRONOUNCED DEAD: February 12, 1967 4:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1744 W. North Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1744 W. North Avenue

15-04

00

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): single

8. DATE OF BIRTH: 2-18-01

9. AGE (In years last birthday): 65

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218053932

17. INFORMANT: Effie Baylor ADDRESS: 1730 North Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive pulmonary thromboemboli

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED February 13, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2-17-67

23C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967

24B. NAME OF REGISTRAR: Robert E. Fairbairn

24C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 N. Calhoun St.

VS 151-REV. 1/1/65

1967000151 6

C-624

BIRTH NO. 67 1515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1515

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CRESWELL, WILLIAM

2. DATE AND HOUR OF DEATH: 14 Feb 67 | 4:10 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: ~~Balto~~
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 19-01
D. STREET ADDRESS (If rural, give location): 316 N. CAREY ST

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3-21-00
9. AGE (In years last birthday): 66
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BALTON CRESWELL
14. MOTHER'S MAIDEN NAME: EMMA CRESWELL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ELIZABETH CRESWELL — ADDRESS: 2457 GRATZ ST.

MEDICAL CERTIFICATION

18. 1778 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Obstructed Gastro-Enterostomy — 3 wks
DUE TO
(B) Gastric Ulcer
DUE TO
(C) Carcinoma of Prostate

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-23-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Obstructed Gastro-Enterostomy
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 13 Dec 19 66 to 14 Feb 19 67, that (I) ~~(we)~~ last saw the deceased alive on 14 Feb 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Michael B. Flynn M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 14 Feb 67
23C. PHYSICIAN'S NAME (Type): MICHAEL B. FLYNN M.D.
23D. ADDRESS: Univ. Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-20-67
24C. NAME of CEMETERY or CREMATORY: Mt. LAWN CEM.
24D. LOCATION (City, town, or county) (State): DELAWARE COUNTY, PA.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: GEORGE KELSON — ADDRESS: 1348 CALHOUN ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1967 000157

48-03-60 TN

BIRTH NO. 67 1516

M.E. CASE NO. 48-03-60

CERTIFICATE OF DEATH

Registered No. 67 1516

1. NAME OF DECEASED (Type or Print): Roland Funderburk

2. DATE AND HOUR OF DEATH: 2/13/67 11:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 7206 ORTH AVENUE 21219

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-16-1900
9. AGE (In years last birthday): 66
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): k Farmer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): SOUTH CAROLINE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: LOU ANNIE ROBINSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 249345154
17. INFORMANT: BCH: RECORDS
ADDRESS: 4940 EASTERN 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CVA - recurrent — INTERVAL BETWEEN ONSET AND DEATH: 6 mos, 2 wks + 2 days

DUE TO

(B) marked dehydration — 2 wks.

DUE TO

(C) Gm (-) sepsis 2° to urinary tract infection — ~2 wks

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: RLL pneumonia.

19A. DATE OF OPERATION: 2/11 cerebral arteriogram.
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 2/10 1967 to 2/13 1967, that (I) (~~we~~) last saw the deceased alive on 2/13 1967 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Phillip L. Hall M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/13/67
23C. PHYSICIAN'S NAME (Type): DR. PHILLIP L. HALL M.D.
23D. ADDRESS: 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-17-67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A.A. Co. Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Fabyan
25C. FUNERAL DIRECTOR: Marshall W. Jones, Jr.
ADDRESS: 1735 Harford Ave.

VS 150-REV. 1/1/65

1967 0 0 1 5 1 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1517 Registered No. 67 1517

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Helena T. Sorrell

2. DATE AND HOUR OF DEATH: 2/12/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2302 Avalon Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 2302 Avalon Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Married	4/19/98	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	USA

13. FATHER'S NAME: Richard Butler

14. MOTHER'S MAIDEN NAME: Eliza Dorsey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: William A. Sorrell, Sr. ADDRESS: 2302 Avalon Ave

MEDICAL CERTIFICATION

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic Heart Disease — 6 months

DUE TO

(B) Generalized Arteriosclerosis — Unknown

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 15 1966 to Feb 12 1967, that (I) (we) last saw the deceased alive on Feb 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Roland T. Smoot M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): ROLAND T. SMOOT M.D.

23D. ADDRESS: 3817 COPLEY RD., BALTO. 15, MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/67	Carver Mem. Park	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 15 1967	[illegible]	Charles R. Law	802 Madison Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
G-500

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1518 Registered No. 67 1518

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles Gainey

2. DATE AND HOUR PRONOUNCED DEAD: 2/13/67 4:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3210 Dorithan Rd.

42

5. SEX: male
6. RACE: colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 9/27/18
9. AGE (In years last birthday): 48
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Gainey
14. MOTHER'S MAIDEN NAME: Lielce Locke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-05-4525
17. INFORMANT: Lizzie Burton ADDRESS: 664 Cokesburg Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Idiopathic myocardial hypertrophy
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia of right middle lobe

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/14/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/18/67
23C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
24B. NAME OF REGISTRAR:
24C. FUNERAL DIRECTOR: Charles R. Law ADDRESS: 802 Madison Avenue

VS 151-REV. 1/1/65

9 6 7 0 0 0 1 5 2 0

K 425

BIRTH NO. 67 1519

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1519

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): George Gray Kelson

2. DATE AND HOUR OF DEATH: February 10, 1967 | 4:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital 1514 Division Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 15-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1348 N. Calhoun Street

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10.12.03
9. AGE (In years last birthday): 63
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mortician -Owner
10B. KIND OF BUSINESS OR INDUSTRY: Funeral Home
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Kelson
14. MOTHER'S MAIDEN NAME: Mathilda Fowler

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-1[illegible]-6[illegible]73
17. INFORMANT: Mrs. Juanita Kelson-1348 N. Calhoun St. ADDRESS

MEDICAL CERTIFICATION

1B. 420.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infarction — 3 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan. 1949 to Feb. 10, 1967, that (I) (~~we~~) last saw the deceased alive on 2.10.67 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (did~~not~~) view the body after death.

23A. SIGNATURE: James D. Carr M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2.11.67
23C. PHYSICIAN'S NAME (Type): James D. Carr M.D.
23D. ADDRESS: 1427 Madison Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/14/67
24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Baltimore Co. Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Fisher M.D.
25C. FUNERAL DIRECTOR: Herbert E. Nutter- 3035 W. North Ave. ADDRESS

VS 150-REV. 1/1/65

1967 0 0 0 1 5 2 2

1
C-520

BIRTH NO. 67 1520

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1520

1. NAME OF DECEASED (Type or Print): JAMES CHANCE

2. DATE AND HOUR PRONOUNCED DEAD: 2-9-67 | 5:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): MERCY HOSPITAL

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Queen Anne
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chester 67-00
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: June 27-1894
9. AGE (In years last birthday): 72
If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oyster Packer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balt. Co; Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James W. Chance
14. MOTHER'S MAIDEN NAME: Mary E. Hook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-22-7886
17. INFORMANT: Mrs. James Chance
ADDRESS: Chester, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E 816.4

(A) Head injuries

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): State Route #552 US Route #50 67-00

21D. TIME OF INJURY (APPROX.) (Month) 2 (Day) 7 (Year) '67 (Hour) 1:05 PM m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Driver in auto-auto collision

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [XX] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): CHARLES S. SPRINGATE, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 2-10-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: Feb. 12
23C. NAME of CEMETERY or CREMATORY: Stevensville
23D. LOCATION (City, town, or county) (State): Stevensville, Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
24B. NAME OF REGISTRAR: Robert E. Fahrney
24C. FUNERAL DIRECTOR: Edgar L. Lane
ADDRESS: Church Hill, Maryland

VS 151-REV. 1/1/65

N 856 2 6 7 0 0 0 1 5 2 3

B-530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1521 Registered No. 67 1521

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Biondi, Jacob

2. DATE AND HOUR OF DEATH: 2:10 A.M. 2/14/67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Ba Ho.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Ba/Ho. 27-16
D. STREET ADDRESS (If rural, give location): 3417 Woodland Ave.

5. SEX: M
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3/14/1888
9. AGE (In years last birthday): 78
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10B. KIND OF BUSINESS OR INDUSTRY: Barber Shop
11. BIRTHPLACE (State or foreign country): Chicago, Illinoise
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Pietro Biondi
14. MOTHER'S MAIDEN NAME: Rose Mirra

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W #1
16. SOCIAL SECURITY NO.: 220-01-3044
17. INFORMANT: Mrs. Ersa M. Biondi
ADDRESS: 3417 Woodland Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4201 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute myocardial infarction

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/14/67 19 to 2/14/67 19 DOA, that (I) (we) last saw the deceased alive on DOA 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. J. Moglen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/14/67
23C. PHYSICIAN'S NAME (Type): L. J. Moglen M.D.
23D. ADDRESS: Sinai Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/17/67
24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Fabiano
25C. FUNERAL DIRECTOR: C. Vernon Lemmon
ADDRESS: 4611 Park Heights Ave.

VS 150-REV. 1/1/65

967001524

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-325

BIRTH NO. 67 1522

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1522

1. NAME OF DECEASED (Type or Print): WATKINS, Bernard Howard

2. DATE AND HOUR OF DEATH: February 12,1967 | 5:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-03

D. STREET ADDRESS (If rural, give location): 1932 Wilkins Ave.,

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: 1-11-15

9. AGE (In years last birthday): 52 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Edward Watkins

14. MOTHER'S MAIDEN NAME: Anna Reardon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): 7-1-42 to 1-15-46

16. SOCIAL SECURITY NO.: 217-07-8437

17. INFORMANT: Records ADDRESS: V. A. Hospital, Baltimore, Md. 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 002.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculosis, Pulmonary, Active — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO Far-Advanced

(B) Possible Lung Abscess

DUE TO

(C) Coma, cause undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from February 4, 1967 to February 12, 1967, that (X) (we) last saw the deceased alive on February 12, 1967 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: David N. Marine M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/13/67

23C. PHYSICIAN'S NAME (Type): DAVID N. MARINE M.D.

23D. ADDRESS: V.A. Hospital, 3900 Loch Raven Blvd. Baltimore, Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/16/1967

24C. NAME of CEMETERY or CREMATORY: Baltimore National

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967

25B. NAME OF REGISTRAR: Robert E. Farkas, M.D.

25C. FUNERAL DIRECTOR: Raymond C. Fink ADDRESS: Glen Burnie, Md.

VS 150-REV. 1/1/65

1967000 1526

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-2001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1523 — Registered No. 67 1523

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAYHUGH HARRIET A.

2. DATE AND HOUR OF DEATH: 2-9-67 2:30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO. 29, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: Howard
C. CITY OR TOWN (If outside city limits, write RURAL and give township): SAVAGE 63-00
D. STREET ADDRESS (If rural, give location): BOX # 166

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	CAUCASION	WIDOWED	5-11-1874	92		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM LEWIS (DEC'D)
14. MOTHER'S MAIDEN NAME: SARAH JANE (DEC'D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 212 12 1486
17. INFORMANT: ST. AGNES RECORDS: WILKENS & CATON AVE — ADDRESS:

MEDICAL CERTIFICATION

18. 204.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Uremia Dehydratation — 36-48 h
DUE TO
(B) Renal Shut Down (Lower Nefron Nefrosis — 60 h
DUE TO
(C) Chronic Leukemia Mielomonocitic Tipe 1

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 5 19 67 to FEBRUARY 9 19 67, that (I) (we) last saw the deceased alive on FEBRUARY 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alyandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-9-67
23C. PHYSICIAN'S NAME (Type): Alyandro Mejia M.D.
23D. ADDRESS: St. Agnes Hospital Caton & Wilkens ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-13-67
24C. NAME of CEMETERY or CREMATORY: Fairfax Cemetery
24D. LOCATION (City, town, or county) (State): Fairfax, Virginia

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Fabian
25C. FUNERAL DIRECTOR: [illegible] Laurel Md.
ADDRESS:

VS 150-REV. 1/1/65

T-521

BIRTH NO. 67 1524

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1521

1. NAME OF DECEASED (Type or Print) Bernard A. Tomczewski
BERNARD ANDREW TOMCZEWSKI

2. DATE AND HOUR OF DEATH 2-12-67 | 9:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Edgemere

D. STREET ADDRESS (If rural, give location) Box 196 ROUTE 10

5. SEX MALE 6. RACE CAUCASIAN 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married 8. DATE OF BIRTH 06-07-31 9. AGE (In years last birthday) 35 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 10B. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES TOMCZEWSKI 14. MOTHER'S MAIDEN NAME ANNA GULCZYNSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service) — ? 16. SOCIAL SECURITY NO. 214-30-6645 17. INFORMANT (Brother) ADDRESS Maryland 21219 Lawrence Tomczewski, Box 196, Rt. 10, Balto.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 204.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE MONOCYTIC LEUKEMIA — 10 days.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-2 1967 to 2-12 1967, that ~~(I)~~ (we) last saw the deceased alive on 2-12 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE Judith Dodrill Gardner M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED 2-12-67

23C. PHYSICIAN'S NAME (Type) JUDITH DODRILL GARDNER, M.D. 23D. ADDRESS THE UNION MEMORIAL HOSPITAL Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/16/67 24C. NAME of CEMETERY or CREMATORY Sacred Heart of Mary Cem. 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 15 1967 25B. NAME OF REGISTRAR Robert E. Fabyan 25C. FUNERAL DIRECTOR John J. Duda, ADDRESS 7922 Wise Ave. Dundalk, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

F-000

BIRTH NO. 67 1525

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1525

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LOUIS J. FOY Sr.

2. DATE AND HOUR PRONOUNCED DEAD: February 11, 1967 6:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - Sparrows Point 53-00

D. STREET ADDRESS (If rural, give location): 1212 Forrest Road #19

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	9/24/98	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired, Crane Opr.	Bethlehem Steel Co.	Pennsylvania	U. S. A.

13. FATHER'S NAME: John Foy

14. MOTHER'S MAIDEN NAME: Gertrude McCrachen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-09-2892

17. INFORMANT (Wife) ADDRESS: Anna M. Foy, 1212 Forrest Dr. Sparrows Point, Maryland 21219

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/15/67

23C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967

24B. NAME OF REGISTRAR: Robert E. Jackson M.D.

24C. FUNERAL DIRECTOR ADDRESS: John J. Duda 7922 Wise Ave. Dundalk, Md.

VS 151-REV. 1/1/65

67 000 1528

R-36b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1526 Registered No. 67 1526

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ellwood Robert Ritter

2. DATE AND HOUR OF DEATH: Feb. 11, 1967 | 12:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-06
D. STREET ADDRESS (If rural, give location): 2751 The Alameda

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5/17/1907
9. AGE (In years last birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired- Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Penna. Railroad
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Ritter
14. MOTHER'S MAIDEN NAME: Mary Tinker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-10-9520
17. INFORMANT: Mrs. Ruth L. Ritter
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
4201		
(A)	Acute Coronary Occlusion	instantaneous
DUE TO (B)	Coronary arteriosclerosis	10 yrs.
DUE TO (C)	Gen. arteriosclerosis	several yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 1960 to Feb 11 1967, that (I) (~~we~~) last saw the deceased alive on Feb 2 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Harry B. Scott M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-13-67
23C. PHYSICIAN'S NAME (Type): Harry B. Scott M.D.
23D. ADDRESS: Medical Arts Bldg.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/15/1967
24C. NAME of CEMETERY or CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Parkville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Ralph E. Fukuma
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

1967000529

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1527 Registered No. 67 1527

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Monika Rauser

2. DATE AND HOUR OF DEATH: Feb. 14, 1967 6 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4721 Alhambra Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-10

D. STREET ADDRESS (If rural, give location): 4721 Alhambra Ave.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widowed	7/26/1881	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Germany	U.S.A.

13. FATHER'S NAME: Richard Fisher

14. MOTHER'S MAIDEN NAME: Josephine Herbert

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		215-50-3275-JI	Mrs. Pauline H. Cobo	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

334X I

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Hemiplegia	1 year
DUE TO (B)	Cerebral arteriosclerosis	15 years
DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1957 to Feb. 14, 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 13, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Donald Jandorf M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2-15-67

23C. PHYSICIAN'S NAME (Type): R. Donald Jandorf M.D.

23D. ADDRESS: 6077 Harford Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/1967	Holy Redeemer	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 15 1967	Robert E. Kaufman M.D.	H.W. Jenkins & Sons Co.	4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

1 5 3 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-57-75 DH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1528 Registered No. 67 1528

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edward J. Herman

2. DATE AND HOUR OF DEATH: 2-14-67 11:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-48

D. STREET ADDRESS (If rural, give location): 724 HIGHWOOD DRIVE #21212

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 6-26-32

9. AGE (In years last birthday): 34

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Comm. Consultant

10B. KIND OF BUSINESS OR INDUSTRY: Communications

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JEROME A. HERMAN

14. MOTHER'S MAIDEN NAME: GLADYS ABBOTT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 218-28-6687

17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue, Baltimore, Maryland #21224 ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignant Melanoma, — 13 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 25 1967 to Feb. 14 1967, that (I) (we) last saw the deceased alive on Feb 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alex Silverman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-14-67

23C. PHYSICIAN'S NAME (Type): ALEX SILVERMAN M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-17-67

24C. NAME of CEMETERY or CREMATORY: Balto. National

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967

25B. NAME OF REGISTRAR: Robert E. Fisher M.D.

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-537

BIRTH NO. 67 1529

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1529

1. NAME OF DECEASED (Type or Print): MARJORIE PARMLEY LENTZ

2. DATE AND HOUR OF DEATH: 2-13-67 | 10:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO 12-01
D. STREET ADDRESS (If rural, give location): 3601 GREENWAY

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 2-10-92
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF
10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): UTAH
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WALTER PARMLEY
14. MOTHER'S MAIDEN NAME: ROSE WEBSTER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-46-1987
17. INFORMANT: (CHART) WM P. LENTZ
ADDRESS: BALTO.

MEDICAL CERTIFICATION

18. 163X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Malignant Consolidation of (R) lung
DUE TO
(B) Carcinoma of (R) Lung with
DUE TO
(C) metastases and pleural effusion.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MD

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-01 1967 to 2-13 1967, that (I) ~~(we)~~ last saw the deceased alive on 2-13 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Frank A. Carozza M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-13-67
23C. PHYSICIAN'S NAME (Type): FRANK A. CAROZZA, M.D.
23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-16-67
24C. NAME of CEMETERY or CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Fulton
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

4-552

BIRTH NO. 67 1530

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1530

1. NAME OF DECEASED (Type or Print): WALTER G. HENNING

2. DATE AND HOUR PRONOUNCED DEAD: February 11, 1967 9:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: BALTO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21228

D. STREET ADDRESS (If rural, give location): 7 Locust Drive

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7/23/08

9. AGE (In years last birthday): 58

If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SUPT.

10B. KIND OF BUSINESS OR INDUSTRY: Md SHIPBUILDING INC.

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frederick Henning

14. MOTHER'S MAIDEN NAME: Elizabeth Apple

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-09-7151

17. INFORMANT: ELIZABETH HENNING ADDRESS: 7 Locust Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Retroperitoneal Hemorrhage

DUE TO

(B) Rupture of Arteriosclerotic Abdominal Aortic Aneurysm.

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2-15-67

23C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery

23D. LOCATION (City, town, or county) (State): Woodlawn Balto Co. Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Edw. S. MacNatt Jr. ADDRESS: 301 Frederick Rd-28

VS 151-REV. 1/1/65

1967000153

H-553

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1531 Registered No. 67 1531

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HAMMOND, VIOLA

2. DATE AND HOUR OF DEATH: 2/13/67 2:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): church Home & Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-04
D. STREET ADDRESS (If rural, give location): 1805 E. Fairmount Ave.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): 86 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): unknown
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family
ADDRESS: Same

MEDICAL CERTIFICATION

1B. 4. 2.0.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) congestive Heart Failure
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: GI bleeding from Duodenal ulcer

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/10 19 67 to 2/13 19 67, that (I) (we) last saw the deceased alive on 2/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): Benito Sung M.D.
23D. ADDRESS: church Home & Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/16/67
24C. NAME of CEMETERY or CREMATORY: Holy Cross Cem
24D. LOCATION (City, town, or county) (State): A A Co. Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Foley M.D.
25C. FUNERAL DIRECTOR: McCully F H
ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

8 0 0 1 5 3 4

A-352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1532 Registered No. 67 1532

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ADAMS, LENA D.

2. DATE AND HOUR OF DEATH: FEBRUARY 12, 1967 7:25A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: ST. AGNES HOSPITAL

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 21225 25-04

D. STREET ADDRESS (If rural, give location): 3432 HANOVER STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	WIDOWED	10-15-85	81				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): POLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALBERT Dutkofsky DEC'D

14. MOTHER'S MAIDEN NAME: CAROLINE (ZUKOWSKI) DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-32-8189

17. INFORMANT: ST. AGNES RECORDS ADDRESS: WILKENS & CATON AVE BALTO., MD. 21229

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis Rt Brain Cortex

DUE TO

(B) ASCVD.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ulcers in Lungs Rt Upper Lobe

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from JANUARY 26, 1967 to FEBRUARY 12, 1967, that (X) (we) last saw the deceased alive on FEBRUARY 12, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. H. Weiss M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): E. H. Weiss M.D.

23D. ADDRESS: ST. AGNES HOSPITAL WILKENS & CATON AVES BALTO., MD. 21229

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-15-1967	Loudon Park Cemetery	Baltimore, Maryland

25A. DATE RECEIVED HEALTH DEPT. FEB 15 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: George J. Gonge ADDRESS: 4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-653

BIRTH NO. 67 1533

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1533

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GISELE CORNET

2. DATE AND HOUR PRONOUNCED DEAD: February 9, 1967 | 11:30 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2722 N. Howard Street

12-06

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	2-8-07	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Houseswife	Homemaker	Paris, France	France

13. FATHER'S NAME: Andrew Trezel

14. MOTHER'S MAIDEN NAME: Bertha ???

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

1B. 434.1 I 012.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

History of long standing Paraplegia due to tuberculosis of spine.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

DATE SIGNED: 2/9/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2-15-67	New Cathedral Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 15 1967	Robert E. Fulmer	Wm. Cook-Brooks Inc.	1217 St. Paul St. Baltimore, Maryland

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 5 3 6

D-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1534 Registered No. 67 1534

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James M Duke

2. DATE AND HOUR OF DEATH: Feb 14, 1967 | 1 20 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Lutherville 23-00
D. STREET ADDRESS (If rural, give location): 26-E. Seminary Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	7/1/01	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Credit Manager	Wholesale grocery	Maryland	U.S.A.

13. FATHER'S NAME: John B. Duke

14. MOTHER'S MAIDEN NAME: Mannie Freeman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.: 212-07-4765

17. INFORMANT: Mrs. Gertrude V. Duke, Same as # 4 ADDRESS

MEDICAL CERTIFICATION

1B. 157X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Shock — 5 hrs
DUE TO
(B) Bowel Obstruction — 5 hrs
DUE TO
(C) Pancreatic Carcinoma

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from Feb 13 1967 to Feb 14 1967, that ☒ (we) last saw the deceased alive on Feb 13 1967 and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (We) ☒ (did not) view the body after death.

23A. SIGNATURE: Joseph Silva M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2-14-67

23C. PHYSICIAN'S NAME (Type): Joseph Silva M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Entombment	Feb.17, 1967	Lorraine Mausoleum	Woodlawn, Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 15 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson ADDRESS: 1050 York Road Towson, Md. 21204

VS 150-REV. 1/1/65

9 6 7 0 0 1 5 3 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released by Approval of Medical Examiner H. Lee

C-552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1535 Registered No. 67 1535

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Cunningham, Sula

2. DATE AND HOUR OF DEATH: 13 Feb 67 17.25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-34
D. STREET ADDRESS (If rural, give location): 3611 Gibbons Ave.

5. SEX: F.
6. RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 05-13-76
9. AGE (In years last birthday): 90
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: NOT KNOWN
14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
SOCIAL SECURITY NO.
17. INFORMANT: MR. Wm. B. Howell - Same
ADDRESS

MEDICAL CERTIFICATION

CERTIFICATION APPROVED BY [redacted]

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 422.1

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Generalized Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Feb. 8
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fatr.
20A. AUTOPSY? (Yes or No): No.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): Feb 6 67
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? Fell

22. I certify that (I) (this hospital) attended the deceased from 6 Feb. 1967 to 13 Feb 1967, that (I) (we) last saw the deceased alive on 13 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. Lee M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 13 Feb. 1967
23C. PHYSICIAN'S NAME (Type): HYONG SOK LEE M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/17/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county) (State): Baltimore MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Ralph E. Fisher M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc.
ADDRESS: 5305 Harford Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

N-245

BIRTH NO. 67 1536

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1536

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MAMIE ~~TWOREK~~ J. NAGORNOWSKI

2. DATE AND HOUR OF DEATH: FEBRUARY ~~15~~ 14, 1967 11:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 29-02
D. STREET ADDRESS (If rural, give location): 2908 OVERLAND AVE.

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: 5/25/~~1886~~ 1895
9. AGE (In years last birthday): 71
If Under 1 Yr. Months: Days: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY?: AMERICAN
13. FATHER'S NAME: HENRY TWOREK
14. MOTHER'S MAIDEN NAME: STEPHANIE ANDRUS
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): (-)
16. SOCIAL SECURITY NO.: 216 10 2216
17. INFORMANT: CHART
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. 165X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RESPIRATORY FAILURE

DUE TO

(B) METASTATIC CARCINOMA OF THE LUNG

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NONE
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1/10 1967 to 2/14 1967, that (I) (we) last saw the deceased alive on 2/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ferdinand C. Rodriguez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): FERDINAND C. RODRIGUEZ M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/18/67.
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS:

VS 150-REV. 1/1/65

9 2 7 0 0 1 5 3 9

S-159

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1537 Registered No. 67 1537

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth M. Spahn

2. DATE AND HOUR OF DEATH: Feb. 14, 1967 9:46 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gould Convalescarium

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-38
D. STREET ADDRESS (If rural, give location): 5805 Hillen Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	white	widowed	7-21-1888	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam Haverkorn
14. MOTHER'S MAIDEN NAME: Theresa Schreiber

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215169235D
17. INFORMANT: Miss Sophia Spahn ADDRESS: same

MEDICAL CERTIFICATION

I — CAUSE OF DEATH

1B. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — (A) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

DUE TO — (B) ASVD. — 7 yrs.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. — DUE TO — (C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1936 19 to 2/14/67 19, that (I) (~~we last~~) saw the deceased alive on 2/13/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Walter E Karfgin M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): WALTER E. KARFGIN M.D.
23D. ADDRESS: 4331 Harford Rd

24A. BURIAL CREMATION, REMOVAL (Specify): burial
24B. DATE: 2-17-67
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Fallon M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc Baltimore, Md. ADDRESS:

VS 150-REV. 1/1/65

M-252-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1538 Registered No. 67 1538

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Mabel L. Messinger
MESSINGER MABEL

2. DATE AND HOUR OF DEATH 2-12-67 12 35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: MARYLAND GEN'L HOSPITAL
(If not in hospital or institution, give street address or location): BALTO. MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: RT 1. BOX 49 B. COUNTY: CARROLL
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WESTMINSTER 56-00
D. STREET ADDRESS (If rural, give location): RT 1- BOX 49

5. SEX: F
6. RACE: CAU.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~MARRIED~~
8. DATE OF BIRTH: 6/17/1898
9. AGE (If years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE.
10B. KIND OF BUSINESS OR INDUSTRY: Her own home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~EFRAIM~~ Ephraim T. MEYERS
14. MOTHER'S MAIDEN NAME: MARY ENGLEMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 195-26-1942
17. INFORMANT: Elmer S. Messinger ~~RT. 5010~~ ADDRESS: R. D. 1-Box 49, Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PROB. CELIAC AXIS THROMBOSIS — 2 DAYS
DUE TO
(B) I
DUE TO
(C) ATRIAL FIBRILLATION

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/11/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ARTERIAL ARTERY THROMBOSIS.
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-11-67 19 to 2-12-67 19, that (I) (we) last saw the deceased alive on 2-12-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. M. Beazley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/12/67
23C. PHYSICIAN'S NAME (Type): ROBERT M. BEAZLEY M.D.
23D. ADDRESS: MARYLAND GEN'L HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial ~~Removal~~
24B. DATE: 2/15/67
24C. NAME of CEMETERY or CREMATORY: Methodist Cemetery
24D. LOCATION (City, town, or county) (State): ~~Littlestown, Pa.~~ Union Mills, Carroll CO. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Richard A. Little ADDRESS: Littlestown, Penn
Little Funeral Home

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
G-416

BIRTH NO. 67 1539

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1539

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gilbert, Gurney R

2. DATE AND HOUR PRONOUNCED DEAD: 2/13/67 1:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 51 S. Carrolton Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 51 S. Carrolton Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	widowed	4/27/1900	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?	B.O.R.R.	Md.	U.S.A.

13. FATHER'S NAME: Harry Gilbert

14. MOTHER'S MAIDEN NAME: Georgia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 705-03-9583

17. INFORMANT: Mr. Frederick Johnston — ADDRESS: 1909 Wolfe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/14/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/17/67	Glen Haven Cem.	Glenburnie, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 15 1967	Robert E. Fankuna	John J. Cowan & Son, Inc.	901 Hollins St. Balt. Md. 21223

VS 151-REV. 1/1/65

1967000 1512

47-95-51 ED

BIRTH NO. 67 1540

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1540

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Joseph Dougherty

2. DATE AND HOUR OF DEATH: 1/21/67 12:05P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave., Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balt
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3549 McShane Way

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10-5-09
9. AGE (In years last birthday): 57
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Dougherty
14. MOTHER'S MAIDEN NAME: Bean

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 225-05-0717
17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md.
ADDRESS # 21224

CAUSE OF DEATH

MEDICAL CERTIFICATION

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

1B. 193.9

(A) DUE TO: pneumonia R lung. — INTERVAL BETWEEN ONSET AND DEATH: 2 days

(B) DUE TO:

(C): glioblastoma multiforme

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: glioblastoma multiforme 3 mo.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from Dec 13 1966 to Jan 21 1967, that ~~I~~ (we) last saw the deceased alive on Jan 21 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. Cameron M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/21/67 12:30 pm
23C. PHYSICIAN'S NAME (Type): E.C. CAMERON M.D.
23D. ADDRESS: Baltimore City Hospitals, 4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 2-14-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: FEB 15 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR:
ADDRESS:

1548

VS 150-REV. 1/1/65

S-36

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1541 Registered No. 67 1541

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William Henry Scott Jr.

2. DATE AND HOUR OF DEATH: 2-12-67 11:10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dukeland St. Nursing & Convalescent Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-03
D. STREET ADDRESS (If rural, give location): 2403 Montebello terrance

5. SEX: M.
6. RACE: Col.
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 2-27-02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tampa, Flordia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Scott
14. MOTHER'S MAIDEN NAME: Hattie Walker
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 695-22-3482
17. INFORMANT: Mrs. Wilhelmina Cragway ADDRESS: 2403 Montebello

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
443X
(A) Cerebral vascular accident
DUE TO
Hypertensive arteriosclerotic
(B) cardio-vascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-24- 1965 to 2-12- 1967, that (I) (we) last saw the deceased alive on 2-12- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C.R. Campbell, M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-12-67
23C. PHYSICIAN'S NAME (Type): C.R. Campbell, M.D.
23D. ADDRESS: 1618 W. North Ave. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-17-67
24C. NAME of CEMETERY or CREMATORY: Flushing Cemetery
24D. LOCATION (City, town, or county): Flushing Long Island (State): New York, New York.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: Robert E. Fallon
25C. FUNERAL DIRECTOR: Martin R Dyett ADDRESS: Mollaneous

VS 150-REV. 1/1/65

S-57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1542 Registered No. 67 1542

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lewessi Smith (Lula)

2. DATE AND HOUR OF DEATH: 2-14-67 | 7⁰⁰ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. of MD. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-08

D. STREET ADDRESS (If rural, give location): 1300 Wildwood Parkway

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Sep.

8. DATE OF BIRTH: 8-12-30

9. AGE (In years last birthday): 36

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beautician

10B. KIND OF BUSINESS OR INDUSTRY: Hairdresser

11. BIRTHPLACE (State or foreign country): S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry McQueen

14. MOTHER'S MAIDEN NAME: Pearlie Leslie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: E. Washington ADDRESS: 3016 Harlem Ave

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Metastatic brain tumor — 2 months

DUE TO

(B) Breast cancer

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-29-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: metastatic brain tumor

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-24 1967 to 2-14 1967, that (I) (we) last saw the deceased alive on 2-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Gulbrandsen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-14-67

23C. PHYSICIAN'S NAME (Type): Jon Gulbrandsen M.D.

23D. ADDRESS: Univ. of MD. Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-17-67

24C. NAME of CEMETERY or CREMATORY: Balto. Nat. Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: R. E. Fahnestock

25C. FUNERAL DIRECTOR: Morton + Dyett ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
H-400

BIRTH NO. 67 1543

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1543

1. NAME OF DECEASED (Type or Print): MARY HALL

2. DATE AND HOUR PRONOUNCED DEAD: February 11, 1967 7:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-08
D. STREET ADDRESS (If rural, give location): 3812 Flowerton Road

46

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH:
9. AGE (In years last birthday): 66
If Under 1 Yr. Months, Days; If Under 24 Hrs. Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Richard Hawkins
14. MOTHER'S MAIDEN NAME: Mary Harlday

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Mattie Matthews
ADDRESS: 3812 Flowerton Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2017-67
23C. NAME of CEMETERY or CREMATORY: National Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
24B. NAME OF REGISTRAR: Robert E. Fankyna
24C. FUNERAL DIRECTOR: Harvey A. Hershey
ADDRESS: 478 W. Biddle St.

VS 151-REV. 1/1/65

1967000 1516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1544 Registered No. 61 67 1544

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary Ann B arnes

2. DATE AND HOUR OF DEATH: 2/12/67 8:25 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BOLTON HILL NURS. & CONV. CENT ER 1400 John Street 21217

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 1006 Webb Court 21202
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore city
D. STREET ADDRESS (If rural, give location): 10-02

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	White	widowed	3/7/1876	91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Maryland, Balto.	USA

13. FATHER'S NAME: HENRY NEWPORT

14. MOTHER'S MAIDEN NAME: ANN LIPLY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: PT.'S CHART ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

(A) MYOCARDIAL INFARCTION

DUE TO

(B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/1/65 19 to 2/12/67 19, that (I) (we) last saw the deceased alive on 2/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature], M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/12/67

23C. PHYSICIAN'S NAME (Type): HOWARD FENWARINE M.D.

23D. ADDRESS: 930 WHITELOCK ST, BALT Md

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/14/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Balto.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home, Inc. ADDRESS: 6500 York Road-21212

VS 150-REV. 1/1/65

967000157

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1545 Registered No. 67 1545

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Kathryn Nina Pontari

2. DATE AND HOUR OF DEATH: Feb. 13, 1967 7:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Va. B. COUNTY: V-13

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Springfield

D. STREET ADDRESS (If rural, give location): 6609 Edsall Rd.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 4/19/53

9. AGE (In years last birthday): 13

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Anthony C. Pontari

14. MOTHER'S MAIDEN NAME: Antoniette Grifone

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Records- US PHS Hospital, Balto, Md. Anthony C. Pontari

ADDRESS: Springfield Va.

MEDICAL CERTIFICATION

18. 204.4 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac arrythmia — Terminal

DUE TO

(B) Electrolyte imbalance & renal failure — 3-4 days

DUE TO

(C) Leukemia infiltration of kidneys — Unknown

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept. 20 1966, to Feb. 13 1967, that (I)/(we) last saw the deceased alive on Feb. 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Donald E. Gutfreund M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/14/67

23C. PHYSICIAN'S NAME (Type): Donald E. Gutfreund, Surgeon (R) M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/17/67

24C. NAME of CEMETERY or CREMATORY: Arlington

24D. LOCATION (City, town, or county) (State): Delaware County, Penna.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Videon Fun. Home

ADDRESS: Drexel Hill Penna.

VS 150-REV. 1/1/65

67 0 0 0 1 5 4 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

M-624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1546 Registered No. 67 1546

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARSHALL, ~~Elbert G.~~ G. ELBERT

2. DATE AND HOUR OF DEATH: ~~2-13-67~~ 2-13-67 | 12 50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOUSE IN PINES

CERTIFICATE AMENDED 2/21/67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: A.A.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 52-00
D. STREET ADDRESS (If rural, give location): 256 GLENGARY GRATH

5. SEX: M
6. RACE: CAU
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: Dec 28, 1888
9. AGE (In years last birthday): 78
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles N. Marshall
14. MOTHER'S MAIDEN NAME: Rosa Redman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W. #1
16. SOCIAL SECURITY NO.: 212-23-5935
17. INFORMANT: Elbert G. Marshall Jr. ADDRESS: Glen Burnie Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism — 2 days
DUE TO Osteoporosis with pathological fracture UP 10 yr.
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 12 1966 to Feb 13 1967, that (I) (we) last saw the deceased alive on Feb 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lester Kolman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 7/13/67
23C. PHYSICIAN'S NAME (Type): Lester Kolman M.D.
23D. ADDRESS: 3700 Park Heights Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Feb. 13, 1967
24B. DATE: Feb. 15, 1967
24C. NAME of CEMETERY or CREMATORY: Spring Hill Cemetery
24D. LOCATION (City, town, or county) (State): Easton, Talbot, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Clark's Funeral Home ADDRESS: Easton, Md.

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2/27/67 - Letter from Lester N. Kolman, M.D., 3700 Park Heights Avenue.

J B Carter

A-520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1547 Registered No. 67 1547

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Warren E. Amos

2. DATE AND HOUR OF DEATH: 2/14/67 12:05 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Harford ~~Baltimore City~~

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Forrest Hill 21050 62-00

D. STREET ADDRESS (If rural, give location): General Delivery Phillips Mill Road

5. SEX: Male 6. RACE: Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married 8. DATE OF BIRTH: 1-09-98 9. AGE (In years last birthday): 69 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Block plant

11. BIRTHPLACE (State or foreign country): Forest Hill, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Amos.

14. MOTHER'S MAIDEN NAME: Mary Jenkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 214-18-3505A

17. INFORMANT: Mary W. Amos ADDRESS: Phillips Mill Road Forest Hill, Md. 21050

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 163 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fulminant pneumonia — 2 weeks.

DUE TO

(B) Carcinoma of the lung — ? several mos

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/9/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of lung

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/9 1967 to 2/14 1967, that (I) (we) last saw the deceased alive on 2/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. L. Hurwitz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ House

23B. DATE SIGNED: 2/14/67

23C. PHYSICIAN'S NAME (Type): Richard L. Hurwitz M.D.

23D. ADDRESS: Johns Hopkins Hospital.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/17/1967

24C. NAME of CEMETERY or CREMATORY: Fairview A.M.E.

24D. LOCATION (City, town, or county) (State): Forest Hill, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Farbman

25C. FUNERAL DIRECTOR: Charles E. Kurtz ADDRESS: Jarrettsville, Md. 21084

VS 150-REV. 1/1/65

1967 0 0 0 1 5 4 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

K-252

BIRTH NO. 67 1548

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1548

1. NAME OF DECEASED (Type or Print): MICHAEL J. KAZANSKI (Kozanowski)

2. DATE AND HOUR PRONOUNCED DEAD: February 15, 1967 3:50 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Home & Hospital

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-03

D. STREET ADDRESS (If rural, give location): 625 S. Bradford Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: Sept. 25, 1900

9. AGE (In years last birthday): 66

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10B. KIND OF BUSINESS OR INDUSTRY: Church Home & Hosp.

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Michael Kozanowski

14. MOTHER'S MAIDEN NAME: Maryanna Kozanowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-01-2207A

17. INFORMANT: Son, Mr. Lawrence Kazanski, ADDRESS: Route 7, Bradshaw, Md. 21021

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1 + 260X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes - PARTIAL

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ PARTIAL and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/15/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/18/67

23C. NAME of CEMETERY or CREMATORY: Holy Rosary

23D. LOCATION (City, town, or county) (State): German Hill Rd. Dundalk, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

24B. NAME OF REGISTRAR: Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR: John J. Duda Inc. ADDRESS: 2829 Hudson St. Balto. Md.

VS 151-REV. 1/1/65

1967 0001551

1

M-460

BIRTH NO. 67 1549

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. ~~67 1549~~

1. NAME OF DECEASED (Type or Print): GEORGE W. MILLER

2. DATE AND HOUR PRONOUNCED DEAD: February 11, 1967 12:03 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 48 Market Place

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-01

D. STREET ADDRESS (If rural, give location): 48 Market Place

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: 10/15/15

9. AGE (In years last birthday): 51

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10B. KIND OF BUSINESS OR INDUSTRY: Toy Barns Inc.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John G. Miller

14. MOTHER'S MAIDEN NAME: Katherine Roettger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 217-07-0328

17. INFORMANT: (Brother) ADDRESS: Albert Miller, 1241 Willow Rd. Dundalk, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 490 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia.

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/17/67

23C. NAME of CEMETERY or CREMATORY: Balto. National Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

24B. NAME OF REGISTRAR: Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR: John J. Duda, 7922 Wise Ave. Dundalk, Md.

VS 151-REV. 1/1/65

1967000 1552

S-35 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1550 Registered No. 67 1550

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Stonestreet Mary L. Mrs.

2. DATE AND HOUR OF DEATH: 2/9/67 6:15 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Maryland, Charles County
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Rural
D. STREET ADDRESS (If rural, give location): Rt. #3 La Plata, Maryland

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5-25-11
9. AGE (In years last birthday): 55 Yrs. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lee Clemens (Robert Lee Clements)
14. MOTHER'S MAIDEN NAME: Florence Thompson (Mary Florence Thompson)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-42-0025
17. INFORMANT: Husband ADDRESS: Mr. Allan A. Stonestreet-Newport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of the Colon
DUE TO
& generalized metastasis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from SEPT. 18 1966 to FEB. 9, 1967, that (I) (we) last saw the deceased alive on FEB. 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Adolfo G. de Perio M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: FEB. 9, 1967
23C. PHYSICIAN'S NAME (Type): Adolfo G. de PERIO M.D.
23D. ADDRESS: Baltimore, Maryland ?

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/13/1967
24C. NAME of CEMETERY or CREMATORY: St. Mary's Cemetery
24D. LOCATION (City, town, or county) (State): Newport, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: Robert E. Fale, M.D.
25C. FUNERAL DIRECTOR: Arehart Funeral Home, Inc., La Plata, Md.
ADDRESS

VS 150-REV. 1/1/65

1967 0 0 1553

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-426

67 1551

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 56-2075 67 1551

1. NAME OF DECEASED (Type or Print): Baylis, Mary Zita

2. DATE AND HOUR OF DEATH: Feb. 13, 1967 | 1-10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital 33rd & Calvert Sts. Balto. Md. 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baldwin 03-00

D. STREET ADDRESS (If rural, give location): Cherry Hill Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W.	Married	10-7-79	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Balto. Maryland	America

13. FATHER'S NAME: Charles Biebelheiser

14. MOTHER'S MAIDEN NAME: Jane T. Cullen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. M. Whitely (daughter) ADDRESS: 5309 Cordela Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 8 19 67 to Feb. 13 19 67, that (I) (we) last saw the deceased alive on Feb. 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang-Kyun Shin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb. 13, 1967

23C. PHYSICIAN'S NAME (Type): SANG-KYUN SHIN, M.D. Alan B. Cohen

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-16-1967	New Cathedral	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 16 1967	Robert E. Fahrney	G. Howard Strong	3207 W. North Ave.,

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65-

0 1 5 5 4

B-201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1552 Registered No. 67 1552

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Biggs George B. 2nd.

2. DATE AND HOUR OF DEATH: 2-13-67 | 8:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bolton Hill Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 2614 Greenmount Ave
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location):

12-93

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	5-27-86	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George B. Biggs, Sr.

14. MOTHER'S MAIDEN NAME: Mary Shields

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 218-05-4445

17. INFORMANT: George B. Biggs, 3d. ADDRESS: 103 Woodwind Rd.

CAUSE OF DEATH

1B. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A.S.C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: a few months

DUE TO

(B) & dehydration

DUE TO

(C) senile

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-30 1966 to 2-13 1967, that (I) (we) last saw the deceased alive on 2-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. Nakazawa M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-13-67

23C. PHYSICIAN'S NAME (Type): Hiroshi NAKAZAWA M.D.

23D. ADDRESS: 521 W Lexington St Balto 1

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-16-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Louis E. Forbush

25C. FUNERAL DIRECTOR: J. Howard Strong ADDRESS: 3109 W North Ave

VS 150-REV. 1/1/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1553 Registered No. 67 1553

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLEN C. SAYER

2. DATE AND HOUR OF DEATH: 2-13-67 | 9:00PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: PENNSYLVANIA
B. COUNTY: V-35
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WAYNESBORO
D. STREET ADDRESS (If rural, give location): 400 E. FIFTH ST.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced (specify))	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	10-15-85	~~74~~ 81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Great Yarmouth, England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. LAMB

14. MOTHER'S MAIDEN NAME: ELLEN SAVORY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. John Cover, ADDRESS: 400 E. Fifth St., Waynesboro Pa.

MEDICAL CERTIFICATION

18. 561.3 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Renal Failure — 8 days
DUE TO
(B) Gram Neg Shock — 11 days
DUE TO
(C) Infection in Ventral Hernia Repair — 26 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: Jan 19 1967

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ventral Hernia

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that ~~I~~ (this hospital) attended the deceased from Jan 16 1967 to Feb 13 1967, that (I) (~~we~~) last saw the deceased alive on Feb 13 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: L. C. Parks M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb 13 1967

23C. PHYSICIAN'S NAME (Type): Leon C. Parks M.D.

23D. ADDRESS: Johns Hopkins Hospital, Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/16/67

24C. NAME of CEMETERY or CREMATORY: Green Hill

24D. LOCATION (City, town, or county) (State): Waynesboro, Franklin Co., Pa.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Foley M.D.

25C. FUNERAL DIRECTOR: Walter H. Grove ADDRESS: Waynesboro, Penna

VS 150-REV. 1/1/65

1967 0 0 1 5 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
D-552

BIRTH NO. 67 1554

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1554

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN F. DOMINIAK, Sr.

2. DATE AND HOUR PRONOUNCED DEAD: February 15, 1967 2:45 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 323 S. Washington Street

2-84

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Feb. 25, 1909	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asbestos Worker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Francis Dominiak
14. MOTHER'S MAIDEN NAME: Maryanna Czaja

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-03-2439
17. INFORMANT: Mrs Martha Dominiak
ADDRESS: 323 S. Washington St.

MEDICAL CERTIFICATION

1B. 491X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Confluent Bronchopneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertensive Cardiovascular Disease

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/15/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-18-1967
23C. NAME of CEMETERY or CREMATORY: St. Stanislaus
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
24B. NAME OF REGISTRAR: Robert E. Fahey
24C. FUNERAL DIRECTOR: Lilly & Zeiler Inc.
ADDRESS: 1901-07 Eastern Ave.

VS 151-REV. 11-63

67 0001557

48-68-67 1B

B-420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1555 Registered No. 67 1555

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bullock, Alice E

2. DATE AND HOUR OF DEATH: 11 Feb. 1967 | 10:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-44
D. STREET ADDRESS (If rural, give location): 3416 E. FAIRMONT AVENUE #21224

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-6-19
9. AGE (In years last birthday): 47
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM BALDWIN
14. MOTHER'S MAIDEN NAME: BERTHA HAWKINS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE ADDRESS #21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Probable Massive Inf MI — 2 hrs.
DUE TO
(B) Arteriosclerotic CVD — unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
abdominal aortic aneurysm or Possible Rupt abdominal aorta — unknown

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11 Feb 1967 to 11 Feb 1967, that (I) (we) last saw the deceased alive on 11 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S.W. Douglas, M.D.
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 11 Feb. 67

23C. PHYSICIAN'S NAME (Type): DR. S.W. DOUGLAS, III M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE-BALTIMORE, MD #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/15/67
24C. NAME of CEMETERY or CREMATORY: Balto. Nat'l Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: Robert E. Fabiano
25C. FUNERAL DIRECTOR: Joseph N. Zannino
ADDRESS: 263 S. Conkling St.

VS 150-REV. 1/1/65

0 1 5 5 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

R. 452

BIRTH NO. 67 1556

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1556

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Alice Rollins

2. DATE AND HOUR PRONOUNCED DEAD: 2/13/67 10:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2271 Madison Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1303

D. STREET ADDRESS (If rural, give location): 2271 Madison Ave.

5. SEX: female

6. RACE: colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Oct.27, 1921

9. AGE (In years last birthday): 45

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): D Domestic Work

10B. KIND OF BUSINESS OR INDUSTRY: Private Family

11. BIRTHPLACE (State or foreign country): Edgecomb CO. N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Amos Hudson

14. MOTHER'S MAIDEN NAME: Clara Lyons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 231-28-7547

17. INFORMANT: Mrs Susie Dupree

ADDRESS: RT2 Box 26 Rocky Mount N.C.

MEDICAL CERTIFICATION

18. 443X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary emphysema

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/14/67

23A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 2/17/67

23C. NAME of CEMETERY or CREMATORY: Bullock Cem. Family lots

23D. LOCATION (City, town, or county) (State): Rocky Mount N.C

24A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

24B. NAME OF REGISTRAR: Robert E. Fairbanks

24C. FUNERAL DIRECTOR: Herbert E. Nutter

ADDRESS: 3035 W. North Ave

VS 151-REV. 1/1/65

1967000559

S-530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1557 Registered No. 67 1557

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SMITH, WILLIAM

2. DATE AND HOUR OF DEATH: 2.15.1967 8.15 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: 16-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 705 N. Monroe St

46

5. SEX: M. 6. RACE: C. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEP. 8. DATE OF BIRTH: 4.6.36 9. AGE (In years last birthday): 30 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Thomas H Smith

14. MOTHER'S MAIDEN NAME: Emily Johnson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Emily Smith ADDRESS: 705 N Monroe St

MEDICAL CERTIFICATION

1B. 322.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) acute Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) acute alcoholic intoxication

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): No

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 2.12.67 19 to 2.15. 19 67, that (I) (we) last saw the deceased alive on 2.15. 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Milos Radojkovic M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2.15.67

23C. PHYSICIAN'S NAME (Type): MILOS RADOJKOVIC M.D.

23D. ADDRESS: LUTHERAN HOSPITAL, BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/18/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

1967 0001560

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N. 615 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1558 Registered No. 67 1558

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary Urbanski

2. DATE AND HOUR OF DEATH: 2-8-1967 9:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 24-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230

D. STREET ADDRESS (If rural, give location): 1416 Richardson St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F.	White	Widow	6-5-1898	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: Malechi

14. MOTHER'S MAIDEN NAME: Medaki

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 245-01-6376-D

17. INFORMANT: Mrs. Rose Shade ADDRESS: 1416 Richardson St.

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ASCVD

DUE TO

(B) CONGESTIVE HEART FAILURE

DUE TO

(C) POSSIE ACUTE MYOCARDIAL INFARCTION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-8 1967 to 2-8 1967, that (I) (we) last saw the deceased alive on 2-8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. Matthew Kaufman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-8-67

23C. PHYSICIAN'S NAME (Type): Matthew Kaufman M.D.

23D. ADDRESS: 1213 Light Street.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/11/67

24C. NAME of CEMETERY: Holy Cross Cemetery

24D. LOCATION (City, town, or county) (State): Anne Arundel, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home, Inc. ADDRESS: 5160 East Fort Avenue

1967 000 1 5160

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J. 212

J. 212

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1559 Registered No. 67 1558

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Walenty Jakubowski (C. Jakobowski)

2. DATE AND HOUR OF DEATH: 2-15-67 | 6:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 24-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore # 21230

D. STREET ADDRESS (If rural, give location): 1522 E. Clement St.

5. SEX: M. 6. RACE: White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married. 8. DATE OF BIRTH: 2-14-1884 9. AGE (In years last birthday): 83 If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grain Trimer 10B. KIND OF BUSINESS OR INDUSTRY: Retired. 11. BIRTHPLACE (State or foreign country): Poland. 12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: Lawrence Jakubowski 14. MOTHER'S MAIDEN NAME: Mary Mentpewicz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-14-0755 17. INFORMANT: Edward Jakubowski ADDRESS: 1522 E. Clement St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.14-157X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident

DUE TO

(B) ASCVD

DUE TO

(C) Adeno CA of stomach

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-27 1967 to 2-15 1967, that (I) (we) last saw the deceased alive on 2-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David J. Steinbauer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 2-15-67.

23C. PHYSICIAN'S NAME (Type): David J. Steinbauer M.D. 23D. ADDRESS: 1213 Light St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2/18/67 24C. NAME OF CEMETERY or CREMATORY: Holy Rosary Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967 25B. NAME OF REGISTRAR: Robert E. Sanborn 25C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home, Inc. ADDRESS: 1502 E. Fort Ave.

VS 150-REV. 1/1/65

5-3631

BIRTH NO. 67 1560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1560

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STUART, PAULINE

2. DATE AND HOUR OF DEATH: 2-14-67 4:55AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVES BALTO., 29, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALTO.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 2537 ARUNAH AVE.

1605

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12-12-01

9. AGE (In years last birthday): 66

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES JOHNSON (DEC'D)

14. MOTHER'S MAIDEN NAME: CORA (DEC'D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 220-07-7098

17. INFORMANT: ST. AGNES RECORDS: WILKENS & CATON AVE ADDRESS

MEDICAL CERTIFICATION

18. 502.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute pulmonary edema

DUE TO

(B) Suppurative bronchitis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 13 19 67 to FEBRUARY 14 19 67, that (I) (we) last saw the deceased alive on FEBRUARY 14, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Korbuly M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-14-67

23C. PHYSICIAN'S NAME (Type): S. KORBULY M.D.

23D. ADDRESS: ST AGNES HOSPITAL -CATON & WILKENS AVE 29

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/17/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Charles A Rice

ADDRESS: 661 W Barre St

563

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-62-31TN

D-620

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1561 Registered No. 67 1561

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BERTIE DORSEY (BERTINA DORSEY)

2. DATE AND HOUR OF DEATH: 2·13·67 | 5 25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: 15-47
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2929 WINDSOR AVENUE 21216

31

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	NEGRO	SINGLE	11-23-97	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM
14. MOTHER'S MAIDEN NAME: MARY LOUISE GREEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: BCH: RECORDS — ADDRESS: 4940 EASTERN AVENUE 21224

MEDICAL CERTIFICATION

18. 199.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinomatosis - primary undetermined — 4 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-1 1967 to 2·13 1967, that (I) ~~(we)~~ last saw the deceased alive on 2·13 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: James T. Corkins M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2·13·67
23C. PHYSICIAN'S NAME (Type): DR. JAMES T. CORKINS M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE BALTO. MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-16-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: Robert E. Fathman
25C. FUNERAL DIRECTOR: Charles F. Rice — ADDRESS: 661 W. Barre St

VS 150-REV. 1/1/65

1
M. 600

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 1562

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1562

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Katie Moore

2. DATE AND HOUR PRONOUNCED DEAD: 2/13/67 3:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01
D. STREET ADDRESS (If rural, give location): 706 N. Carrollton Ave.

36

5. SEX: female
6. RACE: colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 9-20-09
9. AGE (In years last birthday): 57
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willie Harris
14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bertha Hill
ADDRESS: 112 Bradhurst ave, apt 18 N.Y. N.Y.

MEDICAL CERTIFICATION

18. 581.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/14/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-16-67
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
24B. NAME OF REGISTRAR: Robert E. Fahey M.D.
24C. FUNERAL DIRECTOR: Charles A. Rice
ADDRESS: 661 W. Barre St

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 5 6 5

55431

BIRTH NO. 67 1563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1563

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MADISON T. SMALLWOOD

2. DATE AND HOUR OF DEATH: 2-12-67 8:10 am. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLES GENERAL BALTO. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTO. CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 8-06
D. STREET ADDRESS (If rural, give location): 1621 North Dallas St.

5. SEX: M
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3-20-07
9. AGE (In years last birthday): 59
If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY: GAS + Electric
11. BIRTHPLACE (State or foreign country): N. Carolina
12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME: ABE Smallwood
14. MOTHER'S MAIDEN NAME: SARAH BARNES
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-01-4229
17. INFORMANT: Thelma Smallwood — ADDRESS: FROM CHART

MEDICAL CERTIFICATION

1B. 199.2

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARCINOMA OF SIGMOID AND DESCENDING COLON — 38 days
DUE TO
(B) WITH LARG ABSCESS.
DUE TO
(C) CARCINOMA INVOLVING SMALL BOWEL MESETERY LEF URETER w/ OBSTRUCTION, LEFT GUTTER ABSCESS.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-18-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ruptured Ca of desc. colon + SIGMOID
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 1-4- 1967 to 2-12 1967, that ~~I~~ (we) last saw the deceased alive on 2-12-67 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We) (did) (did not)~~ view the body after death.

23A. SIGNATURE: DR. HARRY SHERNAN / J Jan, M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-12-67
23C. PHYSICIAN'S NAME (Type): DR. HARRY SHERNAN M.D.
23D. ADDRESS: 2500 Eutaw Place, 21217

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 10/67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem Park
24D. LOCATION (City, town, or county) (State): Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Bernard T. Eliukonis
ADDRESS: 1129 N. Carlin St

VS 150-REV. 1/1/65

1967 0 0 0 1 5 6 6

J-525

BIRTH NO. 67 1564

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1564

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JENNIE JENKINS

2. DATE AND HOUR PRONOUNCED DEAD: February 9, 1967 12:20 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1019 N. Ensor Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1019 N. Ensor Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	Colored	Widow	Oct. 22, 1881	85	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		N. Carolina	

13. FATHER'S NAME: Samuel Edwards

14. MOTHER'S MAIDEN NAME: Melinda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Phebe Jenkins ADDRESS: 1019 N. Ensor St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/9/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Feb. 13/67	Mt Calvary Cemetery	A. A. County

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 16 1967	Robert E. Farley M.D.	Joseph T. Eftekeare	1129 N. Carlin

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 5 6 7

W 4/10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1565 Registered No. 67 1565

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WOLF, ANNA ELIZABETH

2. DATE AND HOUR OF DEATH: 15 Feb 67 | 1:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 6117-A FALL ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	MARRIED	05-03-09	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: OLIVER B. CURNOLES
14. MOTHER'S MAIDEN NAME: ROBERTA LOWE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-05-0636
17. INFORMANT: Mr. Allan A. Wolf ADDRESS: 6117A Falls Rd. 21209

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) metastatic carcinoma to liver
DUE TO
(B) adrenal cortical adenoma, left
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Y.K. Brim

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9 Feb 1967 to 15 Dec 1967, that (I) (we) last saw the deceased alive on 15 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sidney E. Kirkley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 15 Dec. 67
23C. PHYSICIAN'S NAME (Type): Sidney E. Kirkley M.D.
23D. ADDRESS: The Union Memorial Hospital UNION MEM. HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/18/67
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland 21234

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: Robert E. Faherty
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson ADDRESS: 1050 York Rd. 21204

VS 150-REV. 1/1/65

1967 00 1568

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-5510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1566 Registered No. 67 1566

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Evelyn M. Hyman

2. DATE AND HOUR OF DEATH: 2-15-67 | 1:07 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25 32

D. STREET ADDRESS (If rural, give location): 450 Roundview Road

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 1/8/29

9. AGE (In years last birthday): 38

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Greenville, N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Wiggins

14. MOTHER'S MAIDEN NAME: Emma Leggett

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Richard Hyman

ADDRESS: 450 Roundview Rd.

MEDICAL CERTIFICATION

18. 583X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A)	respiratory arrest	10 min
DUE TO (B)	aspiration pneumonia	6-8 hours
DUE TO (C)	hepatic acute liver failure	7 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): liver bx

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 4 1967 to Feb 15 1967, that (I) (we) last saw the deceased alive on Feb 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel C. Hadlock M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 15 Feb 1967

23C. PHYSICIAN'S NAME (Type): DANIEL C. HADLOCK M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/20/67

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State): Winterville N.C.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Wm C March

ADDRESS: 928 E. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-6125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1567 Registered No. 67 1567

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VASO NMI JEROSIMICH

2. DATE AND HOUR OF DEATH: 2-11-67 12:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: ANNE ARUNDEL

C. CITY OR TOWN (If outside city limits, write RURAL and give township): PASADENA 52-00

D. STREET ADDRESS (If rural, give location): 8406 HALL RD. (Riviera Beach)

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 2-06-97

9. AGE (In years last birthday): 70

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUILDER (Ret.)

10B. KIND OF BUSINESS OR INDUSTRY: BUILDING

11. BIRTHPLACE (State or foreign country): YUGOSLAVIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Jerosimich

14. MOTHER'S MAIDEN NAME: EvA Milivich

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK

If yes, give war or dates of service: None

16. SOCIAL SECURITY NO.: 213-07-7042-A

17. INFORMANT: PATIENT Mrs Lillian Gabrielson (daughter) ADDRESS: 6214 Mc Clean St. Balto. 21214

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute bronchopneumonia

DUE TO

(B) Acute lymphoma

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

A. Bigolito, M.D.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-06 1967 to 2-11 1967, that (I) ~~(we)~~ last saw the deceased alive on 2-09 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Frank Carrozza M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-11-67

23C. PHYSICIAN'S NAME (Type): DR FRANK CARROZZA M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. 14, 1967

24C. NAME of CEMETERY or CREMATORY: Glen Haven Mem. Park

24D. LOCATION (City, town, or county) (State): Glen Brunie, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Richard V. Singleton ADDRESS: Glen Brunie, Md.

VS 150-REV. 1/1/65

1 5 6 7 0 0 0 1 5 7 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620

67 1568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1568

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Cora W. Gross

2. DATE AND HOUR OF DEATH: Feb 15/67 | 4:45 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-01

D. STREET ADDRESS (If rural, give location): 3900 North Charles Street 18

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: June 3, 1877

9. AGE (In years last birthday): 89

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Philip Waldheimer

14. MOTHER'S MAIDEN NAME: Sarah Stern

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lee Eiseman

ADDRESS: same address as above

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Pulmonary Oedema — 30 min

DUE TO

(B) Aortic Stenosis — years

DUE TO

(C) Coronary Arteriosclerosis c Gallbladder — years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): —

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (~~this hospital~~) attended the deceased from ..... 19 ..... to Feb 15 19 67, that (I) (~~we~~) last saw the deceased alive on Feb 15 19 67 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb 15/67.

23C. PHYSICIAN'S NAME (Type): EDWIN S BERSTOCK M.D.

23D. ADDRESS: 3500 N Calvert St Balto Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 2/16/1967

24C. NAME of CEMETERY or CREMATORY: Greenmount Crematory

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Wm. J. Tucker & Sons

ADDRESS: Balto, Md.

VS 150-REV. 1/1/65

1967 0001 57

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-616

Released on approval by Med. Ex.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1569 Registered No. 67 1569

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLEN MULVILLE BARBOUR

2. DATE AND HOUR OF DEATH: 2/13/67 9 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Rogers Forge
D. STREET ADDRESS (If rural, give location): 6806 Blenheim Rd.

5. SEX: F. 6. RACE: White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed 8. DATE OF BIRTH: 10/11/79 9. AGE (In years last birthday): 87 If Under 1 Yr. Months: 4 Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Maryland 12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William J. Mulville 14. MOTHER'S MAIDEN NAME: Emily Jane Waters

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): None 16. SOCIAL SECURITY NO.: 217-07-8408 D 17. INFORMANT: Mr. John K. Barbour, Jr. ADDRESS: same address

MEDICAL CERTIFICATION

1B. 420.0 I 904.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Acute Bronchopneumonia, Bilateral (A) ASHD DUE TO (B) ASHD DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: CHIEF OF AST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 1/27/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ex-L. hip 20A. AUTOPSY? (Yes or No): yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Nursing Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): House of Pines — Nursing Home W. Belvedere — 2525

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1/27/67. 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑ 21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 1/26 1967 to 2/13 1967, that I (we) last saw the deceased alive on 2/13 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: D. S. Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 2/13/67

23C. PHYSICIAN'S NAME (Type): DAVID S. SCHWARTZ, M.D. 23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2/16/1967 24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967 25B. NAME OF REGISTRAR: Robert E. Farber, M.D. 25C. FUNERAL DIRECTOR: Wm. J. Tilmont & Sons ADDRESS: Balto., Md. North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

N 828 867 000 1 3 1 2

B-60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1570 Registered No. 67 1570

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Howard Brown

2. DATE AND HOUR OF DEATH: 2-14-67 | 4.30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 19-01

D. STREET ADDRESS (If rural, give location): 510 N. Carey Street

5. SEX: M 6. RACE: C 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): separated 8. DATE OF BIRTH: 6-12-14 9. AGE (In years last birthday): 52 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repair man 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): U.S.A 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Louis Brown 14. MOTHER'S MAIDEN NAME: Helen Coleman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 215 07 7540 17. INFORMANT: Bessie Brown ADDRESS: 510 N Carey St

MEDICAL CERTIFICATION

18. 1621

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 mon/hs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-4-67 19 to 2-14 19 67, that (I) (we) last saw the deceased alive on 2-14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Carlos Boetsch M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 2-14-67

23C. PHYSICIAN'S NAME (Type): Carlos Boetsch M.D. 23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2/18/67 24C. NAME of CEMETERY or CREMATORY: Mt Zion Ch 24D. LOCATION (City, town, or county) (State): Majestic Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967 25B. NAME OF REGISTRAR: Robert E. Fabian 25C. FUNERAL DIRECTOR: Marsburg Hayes ADDRESS: 238 N Gilmor

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

M-625

67 1571

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1571

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ZEBEDEE MORGAN

2. DATE AND HOUR PRONOUNCED DEAD: February 15, 1967 1:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 907 N. Fulton Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 16-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 907 N. Fulton Avenue

00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored		7-22-1923	43				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	GEN CONTRACTOR	NASHVILLE N.C	USA

13. FATHER'S NAME: WREN MORGAN

14. MOTHER'S MAIDEN NAME: WILLIE A. WIGGINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WWII	238-28-8333	MILLIE C. MORGAN	1611 GWYNNS FALLS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 2 Day

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Sickle Cell Disease

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/15/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Removal	2/17/67	Spring Hope	Nashville N.C

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 16 1967	Robert E. Fabian, M.D.	Marshall P. Hayes	638 N Gilmor St

VS 151-REV. 1/1/65

1967000 1571

1
H-365

BIRTH NO. 67 1572

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1572

1. NAME OF DECEASED (Type or Print): Edward Hawthorne

2. DATE AND HOUR PRONOUNCED DEAD: 2/14/67 9:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: X

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-02

D. STREET ADDRESS (If rural, give location): 1674 Bruce ~~St.~~ Ct.

41

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	colored	MARRIED	9-13-1913	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	MD NAT. BANK	KENBRIDGE VA	USA

13. FATHER'S NAME: EPPA HAWTHORNE

14. MOTHER'S MAIDEN NAME: Lucy Woodson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Daisy Hawthorne ADDRESS: 1674 Bruce Ct

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 490X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia, right upper and middle lobes

~~DUE TO~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fatty alteration of liver

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 2/14/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/18/67	Mt Auburn	Baltimore

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 16 1967	Robert E. Fahey M.D.	Thomas P. Hayes	836 N Gilmor St

VS 151-REV. 1/1/65

1967000 1575

W-32

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1573 Registered No. 67 1573

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FATHER WHITSETT

2. DATE AND HOUR OF DEATH: 2.15.67 3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: NORTH CAROLINA B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): GREENSBORO.
D. STREET ADDRESS (If rural, give location): Last address unknown. / SISTER IS address in Balto 2547 Edmondson AVE

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW.
8. DATE OF BIRTH: —
9. AGE (In years last birthday): 54 yrs. If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: GUS BROWN
14. MOTHER'S MAIDEN NAME: MARY LOU ~~JONES~~ or GAINES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 241-18-9407
17. INFORMANT: BROTHER. / MR EDWARD BROWN ADDRESS: 211 E. Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

153.21 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Pancreas
DUE TO
(B) Metastasis
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2.14 19 67 to 2.15 19 67, that (I) (we) last saw the deceased alive on 2.15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nina C. Rawlings M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2.15.67
23C. PHYSICIAN'S NAME (Type): NINA C. RAWLINGS M.D.
23D. ADDRESS: Md. GENERAL HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/18/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Thomas R Hayes ADDRESS: 638 N Gilmor

VS 150-REV. 1/1/65

0 0 0 1 5 7 6

S-5-1

BIRTH NO. 67 1574

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1574

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BenTon S. SmiTh

2. DATE AND HOUR OF DEATH: 2/13/67 | 4:30 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-01
D. STREET ADDRESS (If rural, give location): 2815 E Orleans St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	12/11/05	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Pauln R.R.	Delaware	

13. FATHER'S NAME: George SmiTh.

14. MOTHER'S MAIDEN NAME: Eva

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Wife	Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 493 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cardiac Arrest
DUE TO
(B) Acute Renal Failure
DUE TO
(C) Pseudomonas Pneumonia.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12/4/67	Intestinal Obst	Yes	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/4 19 67 to 12/13 19 67, that (I) (we) last saw the deceased alive on 12/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. F. Brooker Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/13/67

23C. PHYSICIAN'S NAME (Type): A. E. Brooker Jr. M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/16/67	Oak Lawn	Balto Co

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 16 1967	R. Leslie E. Jackson	A. Heemann	6067 Harford Rd

VS 150-REV. 1/1/65

67 B 0 1577

G-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1575 Registered No. 67 1575

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Priscilla Gant

2. DATE AND HOUR OF DEATH: 2/13/67 2:35 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: ST. MARY'S

C. CITY OR TOWN (If outside city limits, write RURAL and give township): DAMERON 68-00

D. STREET ADDRESS (If rural, give location):

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	NEGROID	SEPARATED	3-3-07	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Walton Gant

14. MOTHER'S MAIDEN NAME: PRISCILLA WALTER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Evelyn D. Gant ADDRESS: 514 N. Calhoun Street Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Failure — ?

DUE TO

(B) ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from JANUARY 19, 1967 to FEBRUARY 13, 1967, that (I) (~~we~~) last saw the deceased alive on JAN FEBRUARY 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: R. Rampton M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/13/67

23C. PHYSICIAN'S NAME (Type): R. RAMPTON M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/16/67

24C. NAME of CEMETERY or CREMATORY: St. Peter Clavers

24D. LOCATION (City, town, or county) (State): Ridge, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: W. Clarke Mattingley ADDRESS: Leonardtown, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
V-536

BIRTH NO. 67 1576

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1576

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH P. VONTRAN

2. DATE AND HOUR PRONOUNCED DEAD: February 14, 1967 9:42 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Baltimore City Hospitals

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore # 21224, 26-11
D. STREET ADDRESS (If rural, give location): 1229 S. Clinton Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Sept. 21, 1902
9. AGE (In years last birthday): (64) 64
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Gunther Brew. Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Vontran
14. MOTHER'S MAIDEN NAME: Victoria Beltz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 213-09-2877
17. INFORMANT: Martha E. Vontran
ADDRESS: Same.

MEDICAL CERTIFICATION

1B. 260X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hypertensive Cardiovascular Disease
DUE TO
(B)
DUE TO
(C) Diabetes Mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
DATE SIGNED: 2/15/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial n
23B. DATE: 2-18-67
23C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery
23D. LOCATION (City, town, or county) (State): 7225 Eastern Blvd, Ba. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
24B. NAME OF REGISTRAR: Robert E. Farber M.D.
24C. FUNERAL DIRECTOR: Charles S. Geiler
ADDRESS: 901 S. Conkling St. Balto., 21224, Md.

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 5 7 9

N-24

BIRTH NO. 67 1577

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1577

1. NAME OF DECEASED (Type or Print): Mary Nichols E. (Mary Nichols

2. DATE AND HOUR OF DEATH: 2/15/67 | 4:00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 817 North Bond Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Widowed	9/10/95	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cambridge Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Stanley

14. MOTHER'S MAIDEN NAME: Mary Patton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

16. SOCIAL SECURITY NO. 214-07-8049

17. INFORMANT: Mary A Nichols — ADDRESS: Same

MEDICAL CERTIFICATION

18. 053.41

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Sepsis.

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/17 1967 to 2/15 1967, that (I) (we) last saw the deceased alive on 2/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: N B Wilson M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/15/67

23C. PHYSICIAN'S NAME (Type): W Stan Wilson M.D.

23D. ADDRESS: JHH

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-18-67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE RECEIVED HEALTH DEPT. FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Fairbrother

25C. FUNERAL DIRECTOR: Chas E Wilson — ADDRESS: 1001 Brantly Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased. Note to coroner: Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-6201

G 620

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1578 Registered No. 67 1578

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elsie Jarris

2. DATE AND HOUR OF DEATH: Feb 14 1967 | A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1631 W. Lafayette Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-03
D. STREET ADDRESS (If rural, give location): 1631 W. Lafayette Ave

5. SEX: Female
6. RACE: ?
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: June 30 1907
9. AGE (In years lost birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Richmond Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E Mosby
14. MOTHER'S MAIDEN NAME: Maggie Hobson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Esther Lansdown
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO Arteriosclerotic Heart Disease — 11 yrs
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2 May 1955 to 14 Feb 1967, that (I) (~~we~~) last saw the deceased alive on 3 Feb 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C. R. Davidson M.D.
Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 15 Feb 67
23C. PHYSICIAN'S NAME (Type): Charles R. Davidson M.D.
23D. ADDRESS: 2034 W North Ave Baltimore Md 21217

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-17-67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: Robert E. Taylor, M.D.
25C. FUNERAL DIRECTOR: Choy J. Wilson
ADDRESS: 1000 Brambleton

VS 150-REV. 1/1/65

5-5-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1579 Registered No. 67 1579

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Sneed

2. DATE AND HOUR OF DEATH: February 10, 1967 6:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Montebello State Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-01

D. STREET ADDRESS (If rural, give location): 1814 W. Franklin St.

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 3-15-99

9. AGE (In years last birthday): 67

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labour

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sam Sneed

14. MOTHER'S MAIDEN NAME: Sarah

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): jw

16. SOCIAL SECURITY NO.: 212-10-5991

17. INFORMANT: Hospital chart ADDRESS:

MEDICAL CERTIFICATION

I

1B. 177 X + 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Adenocarcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 12 1966 to Feb. 10 1967, that (I) (we) last saw the deceased alive on Feb. 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. Pellerano M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-10-67

23C. PHYSICIAN'S NAME (Type): Cesar S. Pellerano M.D.

23D. ADDRESS: Montebello Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-15-67

24C. NAME of CEMETERY or CREMATORY: Corner Cent

24D. LOCATION (City, town, or county) (State): Laurel Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967

25B. NAME OF REGISTRAR: Robert E. Lapenna

25C. FUNERAL DIRECTOR: Elroy O. Walson

ADDRESS: 1000 Brantley Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-236

BIRTH NO. 67 1580

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1580

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALAN ALEXANDER ROYSTER

2. DATE AND HOUR PRONOUNCED DEAD: February 11, 1967 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1405 E. Madison Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-02

D. STREET ADDRESS (If rural, give location): 1405 E. Madison Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	single	July 22 1925	38				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unemployed		Henderson N. Carolina	U.S.A.

13. FATHER'S NAME: Jake Royster

14. MOTHER'S MAIDEN NAME: Alice Southland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): yes

16. SOCIAL SECURITY NO.

17. INFORMANT: Pearl Jarrett ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E702.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Traumatic Injuries.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1405 E. Madison Street 10-02

21D. TIME OF INJURY (APPROX.) (Month) 2 (Day) 11 (Year) '67 (Hour) A m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Fall from upstairs window.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 2/11/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	2-16-67	Balto Nat Cem	Balto	Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 16 1967	Robert E. Farley, M.D.	Elroy A. Wilson	1000 Brantley Ave

VS 151-REV. 1/1/65

N869267000 1583

F-236

BIRTH NO. 67 1581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1581

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Foster

2. DATE AND HOUR OF DEATH: Feb 13 1967 10:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1604 N. Chapel St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1604 N Chapel St

506

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: Jan 3, 1897
9. AGE (In years last birthday): 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elliott City Md
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Wave Frisby
14. MOTHER'S MAIDEN NAME: Mary Wilson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-18-6280
17. INFORMANT: Bertha Johnson
ADDRESS: Same

MEDICAL CERTIFICATION

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial Infarction — Instant

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C) Essential Hypertension — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-14- 1961 to 2-13- 1967, that (I) (~~we~~) last saw the deceased alive on 1-26- 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Eugene H. Owens M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-16-67
23C. PHYSICIAN'S NAME (Type): Eugene H. Owens M.D.
23D. ADDRESS: 1735 E. Federal St
2-16-67

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-19-67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 16 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Elroy Wilson
ADDRESS: 1010 Bramble St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-1-5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1582 — Registered No. 67 1582

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SPENCER, ALBERT

2. DATE AND HOUR OF DEATH: 2/15/67 | 10:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MARYLAND B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21 03400
D. STREET ADDRESS (If rural, give location): 104 MARGARET AVE

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4/26/26
9. AGE (In years last birthday): 40
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINTENANCE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ACIE SPENCER
14. MOTHER'S MAIDEN NAME: BYERS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 723-18-8339
17. INFORMANT: PEGGY SPENCER — ADDRESS: ABOVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 140.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MALIGNANT MELANOMA — 3 MON
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: JAN 13, 1967
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: MALIG MELANOMA
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/30/67 19 to 2/15/67 19, that (I) (we) last saw the deceased alive on 2/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David A Spott M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): D.A. SPOTT M.D.
23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 2/16/67
24C. NAME of CEMETERY or CREMATORY: LEWISBERG
24D. LOCATION (City, town, or county) (State): LEWISBERG W. VA

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967
25B. NAME OF REGISTRAR: Robert E. Fabian M.D.
25C. FUNERAL DIRECTOR: J.G. CONNELLY SONS
ADDRESS: 300 MACE

VS 150-REV. 1/1/65

1967 0 0 1 5 8 8

D-256

BIRTH NO. 67 1583

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1583

1. NAME OF DECEASED (Type or Print): SAMUEL MASON DIXON

2. DATE AND HOUR OF DEATH: FEBRUARY 14, 1967 2:15 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL BALTIMORE MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: CALVERT CO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): HUNTINGTOWN Md. 57-00
D. STREET ADDRESS (If rural, give location):

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6/16/24
9. AGE (In years last birthday): 42
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSPECTOR
10B. KIND OF BUSINESS OR INDUSTRY: PUBLIC WORKS
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SAMUEL H. DIXON
14. MOTHER'S MAIDEN NAME: ~~EMILY DIXON~~ HILDA TROTT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes.
(If yes, give war or dates of service): W. W. II
16. SOCIAL SECURITY NO. 219-12-3704
17. INFORMANT: WIFE - EMILY DIXON
ADDRESS:

MEDICAL CERTIFICATION

18. I 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DIABETIC COMA — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 13 1967 to FEBRUARY 14 1967, that (I) (we) last saw the deceased alive on FEB 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert T. Singleton M.D.
Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: FEB 14, 1967
23C. PHYSICIAN'S NAME (Type): ROBERT T. SINGLETON M.D.
23D. ADDRESS: UNIVERSITY HOSP. BALTO MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 17, 1967
24C. NAME of CEMETERY or CREMATORY: Emmanuel Cem.
24D. LOCATION (City, town, or county) (State): Plum Point, Calvert Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967
25B. NAME OF REGISTRAR: Robert E. Fabian M.D.
25C. FUNERAL DIRECTOR: Hutchins Funeral Home Owings, Md
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-163

BIRTH NO. 67 1584

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1584

1. NAME OF DECEASED (Type or Print): WILLIAMS ROBERTS

2. DATE AND HOUR OF DEATH: 2-14-67 | 10:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE BELVEDERE AT GREENSPRING

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16-08

D. STREET ADDRESS (If rural, give location): 608 LINNARD ST

42

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: DEC-16

9. AGE (In years last birthday): 50

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]

10B. KIND OF BUSINESS OR INDUSTRY: [illegible]

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 246075123

17. INFORMANT: MARY ROBERTS ADDRESS: 608 LINNARD ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B) CHRONIC PYELONEPHRITIS — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. SUPERIOR VENA CAVAL SYNDROME 2° to MEDIASTINAL MASS

19A. DATE OF OPERATION: 0 —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from Jan. 10 1967 to Feb. 14 1967, that (I) (we) last saw the deceased alive on Feb. 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Venturanza M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-14-67

23C. PHYSICIAN'S NAME (Type): L. E. VENTURANZA M.D.

23D. ADDRESS: Sinai Hospital of Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-18-67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: KELSUN FUNERAL HOME ADDRESS: 1348 CALHOUN ST.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-67

Montgomery Co. Md.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1585

BIRTH NO. 67 1585

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Wright Donna Marie

2. DATE AND HOUR OF DEATH: 14 Feb 1967 11:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Carroll

C. CITY OR TOWN (If outside city limits, write RURAL and give township): New Windsor 56-00

D. STREET ADDRESS (If rural, give location): Rt. 1

5. SEX: F

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NM

8. DATE OF BIRTH: 31 March 1964

9. AGE (In years last birthday): 2

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George A. Wright

14. MOTHER'S MAIDEN NAME: Alice Nicodemus

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hospital Chart

ADDRESS

MEDICAL CERTIFICATION

18. 753.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Increased Intracranial Pressure — INTERVAL BETWEEN ONSET AND DEATH: life

DUE TO

(B) Aqueductal Stenosis — life

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 13 Feb 67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Aqueductal Stenosis

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 27 JAN 1967 to 14 Feb 1967, that (I) (we) last saw the deceased alive on 14 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Edward D. LAYNE M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 14 Feb 67

23C. PHYSICIAN'S NAME (Type): Edward D. LAYNE M.D.

23D. ADDRESS: University Hospital Bal. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/14/67

24C. NAME of CEMETERY or CREMATORY: LINGANORE

24D. LOCATION (City, town, or county) (State): UNIONVILLE MD

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: D.D. Hartzler & Sons

ADDRESS: New Windsor Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-6-52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1586 Registered No. 67 1586

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH H. FRANZ

2. DATE AND HOUR OF DEATH: FEB. 14, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4327 MARBLE HALL RD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-09

D. STREET ADDRESS (If rural, give location): 4327 MARBLE HALL RD.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	DEC. 26, 1896	70 YRS.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED TELLER	MARYLAND NAT. BK.	BALTIMORE, MD.	

13. FATHER'S NAME: CHARLES J. FRANZ

14. MOTHER'S MAIDEN NAME: KATHERINE GRIESER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. JOSEPH H. FRANZ ADDRESS: 4327 MARBLE HALL

MEDICAL CERTIFICATION

I

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial infarction — 12 hrs

DUE TO

(B) Arteriosclerotic cardiovascular disease — 8 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Post encephalitic syndrome — 3 yr.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1 1948 to Feb 14 1967, that (I) (~~we~~) last saw the deceased alive on Feb 14 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Frederick J. Vollmer M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb 15 1967

23C. PHYSICIAN'S NAME (Type): FREDERICK J. VOLLMER M.D.

23D. ADDRESS: 6100 YORK RD, BALTIMORE, MD 21212

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2/17/67	CATHEDRAL	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 17 1967	Robert E. Farber M.D.	H. W. MEARS & SON	805 N. CALVERT ST.

VS 150-REV. 1/1/65

1967000 1589

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1.

D-540

BIRTH NO. 67 1587

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1587

1. NAME OF DECEASED (Type or Print): THEODORA M. DONNELLY

2. DATE AND HOUR PRONOUNCED DEAD: February 11, 1967 | 10:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 3227 St. Paul Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02

D. STREET ADDRESS (If rural, give location): 3227 St. Paul Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: JAN. 12, 1902

9. AGE (In years last birthday): 65

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BRITISH, INDIA

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: NIELS MADSEN

14. MOTHER'S MAIDEN NAME: ELIZABETH SARRAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. D. RICHARDSON

ADDRESS: JANE RD. FAIRFIELD N.J

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 8

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 2/15/67

23C. NAME of CEMETERY or CREMATORY: NEW CATHEDRAL

23D. LOCATION (City, town, or county) (State): BALTIMORE, MD.

24A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

24B. NAME OF REGISTRAR: Robert E. Fanlow M.D.

24C. FUNERAL DIRECTOR: N. W. MEARS & SON

ADDRESS: 805 N. CALVERT ST.

VS 151-REV. 1/1/65

1967000 1590

1

0-540

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1588 Registered No. 67 1588

M.E. CASE NO.

43

1. NAME OF DECEASED (Type or Print): WALTER J. O'MELIA	2. DATE AND HOUR PRONOUNCED DEAD: February 7, 1967 7:55 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: ~~New York~~ MD B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Yonkers~~ BALTIMORE 4-02 D. STREET ADDRESS (If rural, give location): 502 W. FAYETTE ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	White	SINGLE	9/23/94	~~64~~ 72	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	UNEMPLOYED	NEW YORK	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
OWEN O'MELIA	MARY SULLIVAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		JOS. O'MELIA	502 W. FAYETTE ST.

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 2/11/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	2/14/67	BALTIMORE NATIONAL	BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 17 1967	Robert E. Farber, MD	H. W. MEARS & SON	805 N. CALVERT ST.

VS 151-REV. 1/1/65

1967 0001591

D-300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1589 Registered No. 67 1589

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): George Irving Ditty

2. DATE AND HOUR OF DEATH: Feb 16, 1967 | 10:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 1307 Park Ave.

5. SEX: Male
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7/23/75
9. AGE (In years last birthday): 91
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Trust Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cyrus Irving Ditty
14. MOTHER'S MAIDEN NAME: Sophia L. Schwartz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 081-10-1169
17. INFORMANT: Mrs Mary B. Ditty
ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2/8 1967 to 2/16 1967, that ~~(I)~~ (we) last saw the deceased alive on 2/16 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Nat E. Watson, Jr. M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/16/67
23C. PHYSICIAN'S NAME (Type): NAT E. WATSON, JR. M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. ~~BURIAL~~ CREMATION, ~~PLACE OF BURIAL~~ & ~~[illegible]~~
24B. DATE: 2/21/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Crematory & Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967
25B. NAME OF REGISTRAR: Robert E. Lark, M.D.
25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home
ADDRESS: 6500 York Rd. Balto., Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1580 Registered No. 67 1590

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT B. CAROZZA

2. DATE AND HOUR OF DEATH: February 13th, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1612 Heathfield Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-09

D. STREET ADDRESS (If rural, give location): 1612 Heathfield Road

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Aug. 1, 1908

9. AGE (In years last birthday): 58

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector, Balto City

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Carozza

14. MOTHER'S MAIDEN NAME: Lucia C. Rinaldi

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 213-03-4915

17. INFORMANT: Mrs. Helen D. Carozza

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Recurrent myocardial infarction — minutes

DUE TO

(B) Arteriosclerotic cardiovascular disease — 3 yr.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary emphysema — 3 yr

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 26 1950 to Feb 13 1967, that (I) (~~we~~) last saw the deceased alive on Feb 13 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Frederick J. Vollmer M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb 16, 1967

23C. PHYSICIAN'S NAME (Type): FREDERICK J VOLLMER M.D.

23D. ADDRESS: 6100 YORK RD BALTIMORE MD 21212

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/16/67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State): Balto.

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

25B. NAME OF REGISTRAR: Robert E. Tarkenna

25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home, Inc. 6509 York Road 21212

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-550

BIRTH NO. 67 1591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1591

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEHMAN, JOSEPH MORTON

2. DATE AND HOUR OF DEATH: 2/15/67 12.45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 27-20
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3712 W. Strathmore Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 5/5/81
9. AGE (In years last birthday): 85
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LAWYER
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael
14. MOTHER'S MAIDEN NAME: Mollie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-05-0064
17. INFORMANT: Son: Jerome
ADDRESS: Same

MEDICAL CERTIFICATION

1B. 204.31

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute leukemia — 6 weeks

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/14 1967 to 2/15 1967, that (I) (we) last saw the deceased alive on 2/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Eduardo Hidalgo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): EDUARDO HIDALGO M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/16/67
24C. NAME of CEMETERY or CREMATORY: Balto Hebrew
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Sylvan S. Levin & Son
ADDRESS: Garrison, Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1592 Registered No. 67 1592

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary Anna Buren.

2. DATE AND HOUR OF DEATH: 2/14/67 - 10:50 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore. 13-06

D. STREET ADDRESS (If rural, give location): 3463 Hickory Ave.

5. SEX: Female

6. RACE: White

7. MARRIED, ~~NEVER MARRIED~~, WIDOWED, ~~DIVORCED~~ (specify): Married

8. DATE OF BIRTH: 4/6/27

9. AGE (In years last birthday): 39

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier

10B. KIND OF BUSINESS OR INDUSTRY: Food Store

11. BIRTHPLACE (State or foreign country): Baltimore.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Unknown Blake

14. MOTHER'S MAIDEN NAME: Unknown Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Blanche Hoile ADDRESS: 4001 Fairhaven Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Total Body Burns - 90% 2nd + 3rd degree.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

E916.0

CERTIFICATION APPROVED BY: Charles J. Poly M.D. CHIEF OF ASST. MEDICAL EXAMINER. 2/16/67

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3463 ~~BLK~~ Hickory Ave. 13-06

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour): 2/13/67 10:45 pm

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑

21F. HOW DID INJURY OCCUR? Burned in house fire

22. I certify that (I) (this hospital) attended the deceased from 2/13 1967 to 2/14 1967, that (I) (we) last saw the deceased alive on 2/14/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: D. A. Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/14/67

23C. PHYSICIAN'S NAME (Type): DR. DAVID S. SCHWARTZ M.D.

23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2 20 67

24C. NAME of CEMETERY or CREMATORY: Balto. U. S. National

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Mc Cully

ADDRESS: 237 Patapsco Av

VS 150-REV. 1/1/65

Release granted by medical examiner 2/14/67 D.A.S.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

H-300

BIRTH NO. 67 1593

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1593

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HERBERT HOOD

2. DATE AND HOUR PRONOUNCED DEAD: February 14, 1967 | 5:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1651 S. Hanover Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-02

D. STREET ADDRESS (If rural, give location): 1651 S. Hanover Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
Male	White	Widowed	7 25 89	77	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Brakeman	Railroad	Balto. Md.	U S A

13. FATHER'S NAME: Henry Hood

14. MOTHER'S MAIDEN NAME: Rebecca Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Herbert Hood Jr. ADDRESS: 1412 Rowe Drive

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/15/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2 18 67	Cedar Hill	Brooklyn, A. A. CO. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 17 1967	Robert E. Falkenau	Mc Cully	130 E. Fort Ave

VS 151-REV. 1/1/65

1967000 1596

G-652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1594 Registered No. 67 1594

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ruth Virginia Grimes

2. DATE AND HOUR OF DEATH: Feb 12, 1967 | 11.00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital, Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Montgomery

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Gaithersburg 65-00

D. STREET ADDRESS (If rural, give location): Bldg 2 Apt 4 North Summit Ave

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9-25-31

9. AGE (In years last birthday): 35

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): U.S.A.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Paul H. Stream

14. MOTHER'S MAIDEN NAME: Sarah C Taylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): (N)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hosp Records, ADDRESS: Same as # 3

MEDICAL CERTIFICATION

1B. 416 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Rheumatic Cardiopathy — 1960

DUE TO

(B) Congestive Heart Failure — Feb 12, 1967

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2-7-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Mitral stenosis, aortic insuff.

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 23 1967 to Feb. 12 1967, that (I) (we) last saw the deceased alive on Feb 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(didn't)~~ view the body after death.

23A. SIGNATURE: Carlos Boetsch M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-12-67

23C. PHYSICIAN'S NAME (Type): Carlos H. Boetsch M.D.

23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/15/67

24C. NAME of CEMETERY or CREMATORY: Monocacy

24D. LOCATION (City, town, or county) (State): Beallsville Montg. Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Wilfred B. Tilton, ADDRESS: Barnesville, Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-220

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1595 Registered No. 67 1595

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Frank K. Lucas

2. DATE AND HOUR PRONOUNCED DEAD: 2/13/67 10:55 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 48 Market Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-01
D. STREET ADDRESS (If rural, give location): 48 Market Place

00

5. SEX	6. RACE	7. MARITAL STATUS (NEVER MARRIED, WIDOWED, DIVORCED) (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	Divorced	12/20/23	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Hurwitz Electric	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Walter Lucas

14. MOTHER'S MAIDEN NAME: Lenora Lowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 217-14-5749

17. INFORMANT: Thelma Lucas (Nee Wolf), wife,
ADDRESS: 1625 Gorsuch Ave. #18

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral pulmonary abscesses
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fatty alteration of liver

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		partial	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy [x] (Partial) and that on this basis, death in my opinion resulted from: Natural causes [x] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [x]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/14/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/20/67	Baltimore National Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 17 1967	Robert E. Farber, M.D.	Schimunek Funeral Home, Inc.	3331 Brehms Lane #13

VS 151-REV. 1/1/65

1967000159 8

B-500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1596 Registered No. 67 1596

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HELEN IRMA BOWEN

2. DATE AND HOUR OF DEATH: Feb. 14, 1967 12:40 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2421 E. Jefferson St. Baltimore, Md. 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 602

D. STREET ADDRESS (If rural, give location): 2421 E. Jefferson St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	divorced	9/27/1911	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Presser Charles	Hirshey Clothing Mfg.	Baltimore, Md.	

13. FATHER'S NAME: Francis Hanafin

14. MOTHER'S MAIDEN NAME: Anna Fisher

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-03-5663

17. INFORMANT: Irene Arthur, dght, 616 N. Clinton St ADDRESS 21205

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 157X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Ca of head of pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

(B) DUE TO:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 49 to 2/14 19 67, that (I) ~~(we)~~ last saw the deceased alive on 2/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Conrad L Richter M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/14/67

23C. PHYSICIAN'S NAME (Type): Dr. Conrad Richter M.D.

23D. ADDRESS: 3128 Harford Road

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/18/67

24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

25B. NAME OF REGISTRAR: Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-600

BIRTH NO. 67 1597

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1597

1. NAME OF DECEASED (Type or Print): CUSTIS LEE ~~CURTIS~~ ~~L.~~ CARR

2. DATE AND HOUR PRONOUNCED DEAD: February 12, 1967 3:08 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hosptial

CERTIFICATE AMENDED 2-17-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Prince George

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Capital Heights 66-00

D. STREET ADDRESS (If rural, give location): 216 61st Street

43

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
Male	White	Never Married	Nov 17, 1932	34	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Delivery driver	Suburban auto parts	Charlottesville, Va	U S A

13. FATHER'S NAME: William J. Carr

14. MOTHER'S MAIDEN NAME: Sara Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
--		579 52 6902	Oscar Poore	Capitol Heights, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral Injury.

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

E816.4

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Ordnance Road and Ritchie Highway, A.A.Co

21D. TIME OF INJURY (APPROX.) (Month) 2 (Day) 12 (Year) '67 (Hour) A.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Driver in auto-auto collision. 52.00

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 2/12/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or ~~CREMATORY~~	23D. LOCATION (City, town, or county) (State)
Burial	Feb 15, 1967	Evergreen Cemetery	Luray Page county Va

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 17 1967	Robert E. Farley, M.D.	Francis Gasch's Sons	Hyattsville, Md.

VS 151-REV. 1/1/65

N 856 1967 0001600

G-342

BIRTH NO. 67 1598

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1598

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): John H. Godleski

2. DATE AND HOUR OF DEATH: February 16, 1967 3 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1000 Scott St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-02
D. STREET ADDRESS (If rural, give location): 1000 Scott St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	3/24/29	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman
10B. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Godleski
14. MOTHER'S MAIDEN NAME: Catherine Forster

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War 2
16. SOCIAL SECURITY NO.: 214-24-0960
17. INFORMANT: Catherine Godleski ADDRESS: 1413 Lowman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Nasopharynx — 7 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/4 1964 to 2/16 1967, that (I) (~~we~~) last saw the deceased alive on 2/15 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: John P. Urlock Jr. M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/17/67
23C. PHYSICIAN'S NAME (Type): JOHN P. URLOCK JR M.D.
23D. ADDRESS: 1227 WASHINGTON BLVD BALTIMORE MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967
25B. NAME OF REGISTRAR: Robert E. Fairbanks
25C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home, Inc
ADDRESS: 1501 E. Fort Avenue

VS 150-REV. 1/1/65

C-625

BIRTH NO. 67 1599

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1599

1. NAME OF DECEASED (Type or Print): HENRY D. CARSON

2. DATE AND HOUR OF DEATH: 2/15/67 2 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Baltimore Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 4919 Windsor Mill Rd.

D. STREET ADDRESS (If rural, give location): 4919 Windsor Mill Road

28-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	MARRIED	3-21-1915	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintainance - Machinist		Johnston, Rhode Island	USA

13. FATHER'S NAME: William Raymond Carson

14. MOTHER'S MAIDEN NAME: Drake

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		035-10-3404	Helen M. Carson	4919 Windsor Mill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) ACUTE MYOCARDIAL INFARCTION

DUE TO

(B) CARDIAC ARREST - Ventricular Fibrillation.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/14 19 67 to 2/15 19 67, that (I) (we) last saw the deceased alive on 2/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Oscar E. Fernandini M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/15/67

23C. PHYSICIAN'S NAME (Type): OSCAR E. FERNANDINI M.D.

23D. ADDRESS: Lutheran Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-18-1967	New Cathedral Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 17 1967	Robert E. Fahrney	Ellsworth Funeral Home	4600 Liberty Hghts. Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-460

BIRTH NO. 67 1600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1600

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MILTON J. WALLER

2. DATE AND HOUR PRONOUNCED DEAD: February 15, 1967 1:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 619 E. Chase Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01

D. STREET ADDRESS (If rural, give location): 619 E. Chase Street

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated

8. DATE OF BIRTH: 4/9/18

9. AGE (In years lost birthday): 48

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Altavista Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Rev G F Waller

14. MOTHER'S MAIDEN NAME: Betty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-14-3348

17. INFORMANT: Mrs Selena Waller ADDRESS: 412 E Biddle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty Metamorphosis of Liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/15/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/19/67

23C. NAME of CEMETERY or CREMATORY: Altavista

23D. LOCATION (City, town, or county) (State): Virginia

24A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

24B. NAME OF REGISTRAR: Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 6 0 3

1

F-432

67 1601

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1601

1. NAME OF DECEASED (Type or Print): LUCIUS FIELDS

2. DATE AND HOUR PRONOUNCED DEAD: February 12, 1967 1:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01

D. STREET ADDRESS (If rural, give location): 1805 Lexington Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH:

9. AGE (In years last birthday): 33

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S Carolina

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Lucious Fields

14. MOTHER'S MAIDEN NAME: Emma Todd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): ?

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Ruby Williams

ADDRESS: 3501 Woodbrook Ave

MEDICAL CERTIFICATION

1B. E982X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cellulitis and septicemia complicating stabwounds of right thigh

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): house

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2543 Mc Henry Street 20-04

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-10-67 10:30 A.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Stabbed during altercation

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: February 13, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/18/67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry

23D. LOCATION (City, town, or county) (State): A A COUNTY Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

24B. NAME OF REGISTRAR: Robert E. Faubayne

24C. FUNERAL DIRECTOR: Adolphus Halstead

ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

N890.B67000160 4

C-656 1

67 1602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1602

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bertha Crowner

2. DATE AND HOUR OF DEATH: 2-14-67 9:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 17-02

D. STREET ADDRESS (If rural, give location): 1115 Myrtle Avenue

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 6-12-06

9. AGE (In years last birthday): 60yrs.

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Eddie White

14. MOTHER'S MAIDEN NAME: Maggie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-20-9942

17. INFORMANT: Miss Ruth Tymese - Niece

ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 330X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage, moderate

DUE TO

(B) Focal subarachnoid hemorrhage

DUE TO

(C) Hemorrhagic bronchopneumonia, bilateral

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 10, 1967 to February 14, 1967, that (I) (we) last saw the deceased alive on February 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-16-67

23C. PHYSICIAN'S NAME (Type): C. Laredo M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/18/67

24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State): Ceder Hill Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 17 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Williams Funeral Home

ADDRESS: 3192 Schroeder St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1603 Registered No. 67 1603

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Carl John Sefa Sr.

2. DATE AND HOUR OF DEATH: Feb. 12, 1967 | 10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-05

D. STREET ADDRESS (If rural, give location): 3903 Mayberry Avenue -21206

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Dec. 19, 1925	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant	Greater Balto. Medical Center	Pittsburg, Pa.	U.S.A.

13. FATHER'S NAME: Joesph Sefa

14. MOTHER'S MAIDEN NAME: Irene Thalheim

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.

17. INFORMANT: Dorothy M. Sefa ADDRESS: 3903. Mayberry Avenue-21206

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Infarction — Sudden

DUE TO

(B) Arteriosclerotic CVD — Years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Dec 17 1966 to Feb 12 1967, that (I) (~~we~~) last saw the deceased alive on Dec 18 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: J. Frank Supplee, III M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/14/67

23C. PHYSICIAN'S NAME (Type): J. Frank Supplee, III M.D.

23D. ADDRESS: 1010 St Paul St, Balt 2, Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-16-67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: John C. Miller Inc. ADDRESS: -6415 Belair Road-21206

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

967000 1606

C-560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1604 Registered No. 67 1604

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CONNOR ~~XXXXXXXX~~ MARY F.

2. DATE AND HOUR OF DEATH: 2/14/67 305 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 25-A2

D. STREET ADDRESS (If rural, give location): 3019 Hollins Ferry Rd.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 5/26/89

9. AGE (In years last birthday): ~~78~~ 77

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John W. Wales

14. MOTHER'S MAIDEN NAME: ~~XXXXXXXX~~ Mary E. Thompson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-01-1643

17. INFORMANT: MARY E. SHIPLEY; ADDRESS: 3019 HOLLINS FERRY Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 1537 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) CARCINOMA PANCREAS

DUE TO

(B)

DUE TO

(C) ARTERIOSCLEROTIC HYPERTENSIVE CARDIOVASCULAR DISEAS WITH ATRIAL FIBRILLATION

INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/8/1967 to 2/14/1967, that (I) (we) last saw the deceased alive on 2/14/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: V. Biswanath Pillai M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): V. BISWANATH PILLAI M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-17-67

24C. NAME of CEMETERY or CREMATORY: Meadowridge Memorial Park

24D. LOCATION (City, town, or county) (State): Dorsey Rd. Howard Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fulton

25C. FUNERAL DIRECTOR: Howard H. Hubbard

ADDRESS: 4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

K-260

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1605 Registered No. 67 1605

M.E. CASE NO.

CERTIFICATE AMENDED 3-3-67

1. NAME OF DECEASED (Type or Print) ETHEL E. ~~KYSER~~ KEYSER	2. DATE AND HOUR PRONOUNCED DEAD February 14, 1967 2:26 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION: University Hospital; IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION:	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland; B. COUNTY: 14-01; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore; D. STREET ADDRESS (If rural, give location): 301 McMecken Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widow	Nov. 17, 1885	81 ~~XX~~		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Housewife	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph O. Wright	Mary E. Walters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	none		H. Stanley Schaefer	70 Oaklee Village

MEDICAL CERTIFICATION

18. E904.6

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cranio-cerebral Injuries

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Store	Lee's Furniture Store, 10 N. Howard St.

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
2	14	'67	1:00 P.M.		Apparently Fell.

4-01

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE R. Breitenecker M.D.

EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED 2/15/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/18/67	Western	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 20 1967	Robert E. Farley M.D.	Howard H. Hubbard	4107 Wilkens Ave.

VS 151-REV. 1/1/65

N856.2967000160 8

V.S. 153 3-3-67 M.H.

M-54

FEB 2 2 14 67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1606

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1606

1. NAME OF DECEASED (Type or Print): MANILOFF, EDITH

2. DATE AND HOUR OF DEATH: 2-14-67 11⁰⁷ A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-13
D. STREET ADDRESS (If rural, give location): 4358 Park Heights Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6/27/10
9. AGE (In years last birthday): 56
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ABE Cohen
14. MOTHER'S MAIDEN NAME: Ida Koltoff

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-01-1438
17. INFORMANT: Mr. Boris Maniloff, 4358 Park Heights Avenue
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Probable Pulmonary Embolism — Immediate
DUE TO
(B) Inactivity + Thrombophlebitis — Several Weeks
DUE TO
(C) Breast Cancer Metastasis — 3½ years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: June 63
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Breast Carcinoma
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 9 1967 to Feb 14 1967, that (I) (we) last saw the deceased alive on Feb 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. C. Parks M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-14-67
23C. PHYSICIAN'S NAME (Type): Leon C. Parks M.D.
23D. ADDRESS: Johns Hopkins Hosp., Balt. Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/15/67
24C. NAME of CEMETERY or CREMATORY: Swinicher Woliner Benevolent ASSN
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Fokerne
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.
ADDRESS: 6010 Reisterstown

VS 150-REV. 1/1/65

7 0 0 1 6 0 2

H-653

BIRTH NO. 67 1607

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1607

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HARMATZ, Bessie

2. DATE AND HOUR OF DEATH: 10:15 PM 2/13/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Balto 28-31

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 4123 Crestheights Rd.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 11/23/76

9. AGE (In years last birthday): 90

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): ? Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Lazer Teper

14. MOTHER'S MAIDEN NAME: ? Cova ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-22-6328

17. INFORMANT: Mr. Leonard Harmatz, 3903 Clarinth Rd. #15

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — 10 hrs

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Art. Scler. Cardiac. Dz

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/13/67 19 to 2/13/67 19, that (I) (we) last saw the deceased alive on 2/13/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/13/67

23C. PHYSICIAN'S NAME (Type): A. Bo Hone M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/15/67

24C. NAME of CEMETERY or CREMATORY: Hebrew Friendship

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Sol Levinson & Bros Inc., 6010 Reist., Rd.

ADDRESS

VS 150-REV. 1/1/65

B-206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1608 Registered No. 67 1608

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Donald L. Bush.Sr

2. DATE AND HOUR OF DEATH: February 15,1967 | 12.45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2820 Huntingdon Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 2820 Huntingdon Ave

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Dec 11,1931
9. AGE (In years last birthday): 35
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: American Service Station
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Elmer W. Bush.
14. MOTHER'S MAIDEN NAME: Hilda Foreman.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes
(If yes, give war or dates of service): Korean
16. SOCIAL SECURITY NO.: 216 2853 34
17. INFORMANT: Anna M. Bush. ADDRESS: 2820 Huntingdon Ave

MEDICAL CERTIFICATION

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Infarction — Sudden
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypercholesterolemia

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): None
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1/7 19 63 to 4/29 19 66, that (~~I~~) (we) last saw the deceased alive on 2/14/67 19 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Herman Brecher M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): HERMAN BRECHER, M.D. M.D.
23D. ADDRESS: 443 E. 25th St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/17/67
24C. NAME of CEMETERY or CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Frederick Road, Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Austin E. Donovan
ADDRESS: 3818 Roland Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Subject to Medical Examiner Approval

A-146

BIRTH NO. 67 1609

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1609

1. NAME OF DECEASED (Type or Print): WALTER APPLER

2. DATE AND HOUR OF DEATH: 2/13/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: ~~4212 Arizona Ave.~~, Md

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01

D. STREET ADDRESS (If rural, give location): 4212 Arizona Ave

5. SEX: M

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 11/4/06

9. AGE (In years last birthday): 60

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY: Dairy Salesman

11. BIRTHPLACE (State or foreign country): Md Sykesville

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Charles Appler

14. MOTHER'S MAIDEN NAME: Katherine Kirby

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W 11

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. S. Madline Appler. ADDRESS: 5626 Anthony Ave. Balto. Md

MEDICAL CERTIFICATION

1B. 230X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) pulmonary edema

DUE TO

(B) Cirrhosis of liver

DUE TO

(C) pancreatic tumor (?)

INTERVAL BETWEEN ONSET AND DEATH

U.K. Bmc.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7:45 pm, Feb 12 1967 to 4:25 pm Feb-13 1967, that (I) (we) last saw the deceased alive on 4:25 pm. Feb 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Won Song M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb-13, 1967

23C. PHYSICIAN'S NAME (Type): SANG WON SONG, M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-16-1967

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore City Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Lazarah Funeral Home

ADDRESS: 7401 Belair Road

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
G-650

BIRTH NO. 67 1610

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1610

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Samuel H. Greene

2. DATE AND HOUR PRONOUNCED DEAD: 2/13/67 6:35 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 24 N. Mount St.

36

5. SEX: male
6. RACE: colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Sep.
8. DATE OF BIRTH: Jan. 10 1898
9. AGE (In years last birthday): 69
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Greene
14. MOTHER'S MAIDEN NAME: Agnes Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-20-3757
17. INFORMANT: Samuel B. Greene ADDRESS: 1646 Ashburton St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. E900.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral injury with subdural hematoma
~~DUE TO~~ –

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 24 N. Mount St. 19-02
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2 12 67 9:30 p.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? fell down steps

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 2/14/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/17/67
23C. NAME of CEMETERY or CREMATORY: Baltimore National
23D. LOCATION (City, town, or county) (State): Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Arlington J. Phillips ADDRESS: 1727 N. Mount St.

VS 151-REV. 1/1/65

N 83927 0 0 0 1 6 1 3

F-622

BIRTH NO. 67 1611

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1611

1. NAME OF DECEASED (Type or Print): Ferguson Garfield

2. DATE AND HOUR OF DEATH: February 12th 1967 at 4 p. m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-32

D. STREET ADDRESS (If rural, give location): 2701 Fisk Rd. #25

5. SEX: M

6. RACE: Col.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 4/15/83

9. AGE (In years last birthday): 83

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): 4/14 83 Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bulter

14. MOTHER'S MAIDEN NAME: Leticlia Menefee

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ?

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 235-10-2105

17. INFORMANT: Roberta Ferguson

ADDRESS: Same

CAUSE OF DEATH

1B. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Benign Prostatic Hypertrophy

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart failure, Chronic lung insufficiency

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 1/30 and 2/3/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Benign Prostatic Hypertrophy

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 25th 1967 to Febr 12th 1967, that (I) (we) last saw the deceased alive on Febr 12th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Vigl. Jón Thorsteinsson M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Febr. 12th 67

23C. PHYSICIAN'S NAME (Type): Viglyndur Thor Thorsteinsson M.D.

23D. ADDRESS: University Hospital, Balte

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/18/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Gd.

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Faber M.D.

25C. FUNERAL DIRECTOR: Arlington S. Phillips

ADDRESS: 1727 Monroe St.

967000

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-560

BIRTH NO. 67 1612

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1612

1. NAME OF DECEASED (Type or Print): SYLVIA W. LINER

2. DATE AND HOUR OF DEATH: 2/16/67 1:15 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-05

D. STREET ADDRESS (If rural, give location): 2411 West Lafayette Street

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Married	8/21/25	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Perry Wright

14. MOTHER'S MAIDEN NAME: Sarah Robinson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-20-4373

17. INFORMANT: John Liner — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA

DUE TO

(B) CHRONIC GLOMERULO NEPHRITIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 1/23 1967 to 2/16 1967, that (I) (we) last saw the deceased alive on 2/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. Rampton M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/16/67

23C. PHYSICIAN'S NAME (Type): R. Rampton M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Friendship

24D. LOCATION (City, town, or county) (State): Wetipquin Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: Arlington Phillips — ADDRESS: 1720 N. Monroe St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-5212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1613 Registered No. 67 1613

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Daniel James Wongus

2. DATE AND HOUR OF DEATH: 2/16/1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2929 Riggs ave. Baltimore Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 2929 Riggs Avenue

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: 6/8/1897
9. AGE (In years last birthday): 69
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mitchell Wongus
14. MOTHER'S MAIDEN NAME: Rosa J. Hopkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rosetta D. Evans ADDRESS: Same

MEDICAL CERTIFICATION

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebrovascular Disease DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 9 years

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-26 1958 to 2-16 1967, that (I) (~~we~~) last saw the deceased alive on 1-25 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: William H Watts M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-17-67
23C. PHYSICIAN'S NAME (Type): William H Watts M.D.
23D. ADDRESS: 515 Arlington Bldg 130 W. Lexington St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: Lincoln Memorial
24D. LOCATION (City, town, or county) (State): Suitland Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Falkenna
25C. FUNERAL DIRECTOR: Boyd's Funeral Home
ADDRESS: Washington D.C.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-36

BIRTH NO. 67-02402 67 1614

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1614

1. NAME OF DECEASED (Type or Print): baby girl STRAND

2. DATE AND HOUR OF DEATH: 12:35 pm 2/7/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE —

B. COUNTY Balto

C. CITY OR TOWN — (If outside city limits, write RURAL and give township)

D. STREET ADDRESS — (If rural, give location): 1739 Glen Ridge Road

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): —

8. DATE OF BIRTH: 2/6/67

9. AGE (In years last birthday): 12 hours

If Under 1 Yr.: Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John

14. MOTHER'S MAIDEN NAME: Dorothy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: —

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory distress syndrome — INTERVAL BETWEEN ONSET AND DEATH: immediate at birth

DUE TO

(B) prematurity

DUE TO

(C) Premature Previable female infant. (autopsy)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chulewski MD

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ — Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 2/6 1967 to 2/7 1967, that (I) (we) last saw the deceased alive on 2/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mona Belinic M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/7/67

23C. PHYSICIAN'S NAME (Type): MONA BELINIC M.D.

23D. ADDRESS: Union Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): —

24B. DATE: 2-10-67

24C. NAME of CEMETERY or CREMATORY: UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State): ANATOMY BOARD OF MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS: 1617

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-03062 67 1615 Registered No. 67 1615

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABY GIRL "B" ELLIS

2. DATE AND HOUR OF DEATH: 2/5/67 7:05 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 1132 W. Saratoga St.

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 2/5/67
9. AGE (In years last birthday): 3 hrs 13 MIN — If Under 1 Yr. Months: Days: Hours: 3 Min.: 13
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTIMORE MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME: DONALD SMITH
14. MOTHER'S MAIDEN NAME: ELAINE ELLIS
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: —
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMATURITY — 3 hrs 13 MIN

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/5 1967 to 2/5 1967, that (I) (we) last saw the deceased alive on 2/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Corazon P. Arellano M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/5/67
23C. PHYSICIAN'S NAME (Type): CORAZON P. ARELLANO M.D.
23D. ADDRESS: UNIVERSITY HOSPITAL BALTIMORE MD

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 2-17-67
24C. NAME of CEMETERY or CREMATORY: JOHNS HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-420

67-03061

BIRTH NO. 67 1616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1616

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Ellis "A"

2. DATE AND HOUR OF DEATH: 2/5/67 11 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 18-02

D. STREET ADDRESS (If rural, give location): 1132 W. Saratoga St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	N		2/5/67				10	46

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald Smith

14. MOTHER'S MAIDEN NAME: Elaine Ellis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Chart

ADDRESS:

MEDICAL CERTIFICATION

18. 773.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hyaline respiratory distress syndrome — Birth

DUE TO

(B) Prematurity — "

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/5 19 67 to 2/5 19 67, that (I) (we) last saw the deceased alive on 2/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ruth E. Loddy M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/5/67

23C. PHYSICIAN'S NAME (Type): RUTH E. LODDY M.D.

23D. ADDRESS: University

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 2-17-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

JOHNS HOPKINS MEDICAL SCHOOL

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-653

67-02004

BIRTH NO. 67 1617

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1617

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY BOY BARNETT

2. DATE AND HOUR OF DEATH: 1/29/67 9:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL BALTO MD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO
D. STREET ADDRESS (If rural, give location): 1510 Washington St #13 UNIV HOSP BARN FR. SG HOSP

8-07

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 1/29/67
9. AGE (In years last birthday):
If Under 1 Yr. Months: Days: Hours: 9 Min.: 12

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD-USA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. BARNETT
14. MOTHER'S MAIDEN NAME: EQUELLA THOMAS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ELLIOT S. TOKAR MD
ADDRESS: UNIV HOSP

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 776X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PREMATURITY — 9 hrs 12 min
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/29/67 19 to 1/29/67 19, that (I) (we) last saw the deceased alive on 9:30 AM 1-29-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Elliot S Tokar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/29/67
23C. PHYSICIAN'S NAME (Type): ELLIOT S. TOKAR M.D.
23D. ADDRESS: UNIV HOSPITAL BALTO MD

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 2-17-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Fadeyma
25C. FUNERAL DIRECTOR:
ADDRESS:

VS 150-REV. 1/1/65

H-553

67-03568

BIRTH NO. 67 1618

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1618

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY BOY Hinnant

2. DATE AND HOUR OF DEATH: 2-12-67 | 3 45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 13-02

D. STREET ADDRESS (If rural, give location): 2100 MT. ROYAL TERRACE, #17

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): —

8. DATE OF BIRTH: 2-11-67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 4 Min.: 55

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): BALT. MD.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: LEE HINNANT

14. MOTHER'S MAIDEN NAME: GLORIA. ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: CHART - ADDRESS:

MEDICAL CERTIFICATION

1B. 226X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMATURITY

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 4 55 min.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-11 - 1967 to 2-12 - 1967, that (I) (we) last saw the deceased alive on 2-12- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mary E. Keeler M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-12-67

23C. PHYSICIAN'S NAME (Type): MARY E. KEELER M.D.

23D. ADDRESS: UNIV. HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 2-17-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fashey M.D.

25C. FUNERAL DIRECTOR:

ADDRESS:

VS 150-REV. 1/65

P-625

67-01773 67 1619

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1619

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Girl of Alma Perkins

2. DATE AND HOUR OF DEATH: 1-31-67 7:30A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 8-03

D. STREET ADDRESS (If rural, give location): 1511 Kenhill Avenue

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 1-29-67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 2 Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Alma Perkins

ADDRESS: SAME

MEDICAL CERTIFICATION

18. 22/5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Hemorrhage - Site? Etiol?

DUE TO

(B) Prematurity

DUE TO

(C) Low - birth wt.

INTERVAL BETWEEN ONSET AND DEATH: 6-12 hrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 29, 1967 to January 31, 1967, that (I) (we) last saw the deceased alive on January 31, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mercado M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-1-67

23C. PHYSICIAN'S NAME (Type): Dr. Mercado M.D.

23D. ADDRESS: 1511 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 2-16-67

24C. NAME of CEMETERY or CREMATORY: JOHNS HOPKINS MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State): ANATOMY BOARD OF MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

VS 150-REV. 1/1/65

R-534

BIRTH NO. 67 1620

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1620

1. NAME OF DECEASED (Type or Print): MARY RANDALL

2. DATE AND HOUR OF DEATH: 2-9-67 12.15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-01

D. STREET ADDRESS (If rural, give location): 3906 CLOVERHILL ROAD 21218

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7-31-98

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: SAMUEL BUSBY

14. MOTHER'S MAIDEN NAME: JULIA VAN NESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT:

ADDRESS:

MEDICAL CERTIFICATION

18. 420.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARDIO-RESPIRATORY ARREST. — 10 min

DUE TO

(B) IDIOVENTRICULAR RHYTHM. — 2 hours.

DUE TO

(C) POSSIBLY ATEROSCLEROTIC HEART DISEASE C AUTOMATIC PACE MAKER — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — ACUTE SUB-DURAL HEMATOMA OPERATED AS EMERGENCY — 24 HOURS

CERTIFICATION APPROVED BY: J. Schuhr

CHIEF OR ASST. MEDICAL EXAMINER

M.D.

19A. DATE OF OPERATION: 2-8-1967

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ACUTE SUBDURAL HEMATOMA

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☐ ☒

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3906 Cloverhill Rd ~~2-8-67 morning~~

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): Feb 8 1967 10:00 A.M.

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑

21F. HOW DID INJURY OCCUR?: Fell down steps at home

22. I certify that (I) (this hospital) attended the deceased from Feb. 8th 1967 to Feb 9th 1967, that (I) (we) last saw the deceased alive on Feb 9th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F Velasco. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-9-1967

23C. PHYSICIAN'S NAME (Type): F. VELASCO M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 2-10-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

26. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

(Dr. Fisher) Mr. Breitenecker

VS 150-REV. 1/1/65

THE BODY OF MARY RANDALL WAS RELEASED ON APPROVAL BY DOCTOR LINTHICUM OF THE MEDICAL EXAMINERS OFFICE **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

L-325

67 1621

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1621

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clarence Ladson

2. DATE AND HOUR PRONOUNCED DEAD: 1/21/67 1:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02

D. STREET ADDRESS (If rural, give location): 628 Sarah Ann Ave.

5. SEX: male

6. RACE: colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years last birthday): 52

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MEDICAL CERTIFICATION

1B. E903.5

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral injury

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): in front of 628 Sarah Ann St. 4-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1 16 67 ? m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Apparently fell.

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 1/22/67

ANATOMY BOARD OF MARYLAND

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE 2-9-67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL

24A. DATE REC'D BY HEALTH DEPT. FEB 20 1967

24B. NAME OF REGISTRAR Robert E. Fa...

24C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

VS 151-REV. 1/1/65

N 836 967 0001621

H-655

BIRTH NO. 67 1622

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1622

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN HERMAN

2. DATE AND HOUR PRONOUNCED DEAD: 1-31-67 7:43 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 16 MARKET PLACE (Crew of Amb. #7)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 16 Market Place 21202

4-01

00

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): 70 ?
If Under 1 Yr. Months Days Hours Min. / If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

1B. 490X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Abscess of lung

Lobar and bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Partial
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ Partial and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1-31-67

23A. BURIAL CREMATION, REMOVAL (Specify):
23B. DATE: 2-9-67
23C. NAME of CEMETERY or CREMATORY:
23D. LOCATION (City, Town, or County) (State):

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 151-REV. 1/1/65

1967000625

43-41-38 ED B-630

BIRTH NO. 67 1623

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1623

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Barrett, William

2. DATE AND HOUR OF DEATH: Jan. 31, 1967 | 8 Lo A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave., Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-12
D. STREET ADDRESS (If rural, give location): 4940 Eastern Ave.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 3-10-04
9. AGE (In years last birthday): 62 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md. ADDRESS # 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolus — 1 day

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: CVA + intestinal obstruction

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 23 1965 to Jan. 31 1967, that (I) (we) last saw the deceased alive on Jan. 31 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ross T. Krueger M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Jan. 31, 1967
23C. PHYSICIAN'S NAME (Type): Ross T. Krueger M.D.
23D. ADDRESS: 4940 Eastern Ave., Baltimore, Md. Balt. City Hosp. # 21224

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 2-14-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR:
ADDRESS:

0 1 6 2 6

VS 150-REV. 1/1/65

K-510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1624 Registered No. 67 1624

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Knepp, Karl Edgar

2. DATE AND HOUR OF DEATH: 2/15/67 6:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL Hospital, BALTIMORE, MD

CERTIFICATE AMENDED 3-13-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE — 21202 11-02
D. STREET ADDRESS (If rural, give location): 28 E. PRESTON ST.

5. SEX: MALE
6. RACE: CAUCASIAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: ~~8/15/10~~ 8/11/10
9. AGE (In years last birthday): 56
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CAB DRIVER.
10B. KIND OF BUSINESS OR INDUSTRY: YELLOW CAB
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~JOHN~~ KNEPP, ROSWELL E.
14. MOTHER'S MAIDEN NAME: ~~MABEL~~ (?) ANNA L. CASNER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Yes UNKNOWN WW 2
16. SOCIAL SECURITY NO.: 188 07 0358
17. INFORMANT: Mr. Courtney L. Hughes, 13112 Hathaway Dr. Silver Springs, Md. ADDRESS ~~WIFE-ON ADMISSION~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) GI-hemorrage — 11 days
DUE TO
(B) Esophageal varicies — unknown
DUE TO
(C) Laennec's Cirrhosis — "

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (1) Hepatic cancer, (2) pneumonia

19A. DATE OF OPERATION: NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: NONE
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): NONE
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): NONE
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? NONE

22. I certify that (I) (this hospital) attended the deceased from 2/4 1967 to 2/15 1967, that (I) (we) last saw the deceased alive on 2/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fred R. Eilber M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): FRED R. EILBER M.D.
23D. ADDRESS: MARYLAND General Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/19/67
24C. NAME of CEMETERY or CREMATORY: LING MEMORIAL CEM.
24D. LOCATION (City, town, or county) (State): LEWISTOWN, MIFFLIN CO. PA.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert B. Jackson
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc. ADDRESS: 1217 St. Paul St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

Dirvorce Decree and V.S. 153 3-13-67
M.H.

R-5413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1625 Registered No. 67 1625

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): REYNOLDS, MARGARET FRANCES

2. DATE AND HOUR OF DEATH: 16 Feb 67 | 2:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-05
D. STREET ADDRESS (If rural, give location): 2021 N. CHARLES ST

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 10-19-08
9. AGE (In years last birthday): 58
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): ~~[illegible]~~, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CALDER
14. MOTHER'S MAIDEN NAME: Unk.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis
DUE TO
(B) Primary Carcinoma of (R) Breast.
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

[illegible] MD

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 13 Feb 1967 to 16 Feb 1967, that ~~(I)~~ (we) last saw the deceased alive on 16 Feb 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Sidney E. Kirkley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 16 Feb 67
23C. PHYSICIAN'S NAME (Type): SIDNEY E. KIRKLEY M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/18/67
24C. NAME of CEMETERY or CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc.
ADDRESS: Baltimore, Md. 21202

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-515

BIRTH NO. 67 1626

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1626

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH CAMPANELLA

2. DATE AND HOUR PRONOUNCED DEAD: February 15, 1967 5:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Maryland General Hpsital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Glen Arm 53800

D. STREET ADDRESS (If rural, give location): Manor Road 21057

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	White	Married	Sept. 3, 1930	36	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
General Manager	Profession Football	Cleveland, Ohio	U.S.A.

13. FATHER'S NAME: Camillo Campanella

14. MOTHER'S MAIDEN NAME: Carmella Ratino

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	Korean Conflict	302-22-7770	Mrs. Nanette Campanella	same as 2C & 2D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congenital Hypoplasia of Coronary Arteries.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 2/16/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Feb 18, 1967	Prospect Hill Cemetery	Towson, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 20 1967	Robert E. Fankuna	Wm. Cook-Brooks Towson	1050 York Road Towson, Md. 21204

VS 151-REV. 1/1/65

1967 D 001629

N-400 1

67-04097

BIRTH NO. 67 1627

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1627

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JULIE ANNE NEELY ~~Baby~~ ~~Girl~~ ~~Neely~~

2. DATE AND HOUR OF DEATH: 2-18-67 | 6 34 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Timonium 53-00
D. STREET ADDRESS (If rural, give location): 113 Greenmeadow Drive

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Never Married	2-16-67	----------		2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	U.S.A.

13. FATHER'S NAME: William D. Neely

14. MOTHER'S MAIDEN NAME: Julia Torrey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. William D. Neely, ADDRESS: Same as # 4

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — 1B. 7600 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 33 hours.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	Yes.	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 2-16 1967 to 2-18 1967, that (I) (we) last saw the deceased alive on 2-18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Perry S. Shelton M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-18-67

23C. PHYSICIAN'S NAME (Type): Perry S. Shelton M.D.

23D. ADDRESS: Mercy Hospital.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-20-1967	Calvary Cemetery	Fairfax Virginia

25A. DATE REC'D BY HEALTH DEPT. FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, ADDRESS: 1050 York Rd. Towson, Md. 21204

VS 150-REV. 1/1/65

1630

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P-636

BIRTH NO. 67 1628

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1628

1. NAME OF DECEASED (Type or Print): MARY PORTER

2. DATE AND HOUR OF DEATH: 2-16-67 5:55 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen'l Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53 00

D. STREET ADDRESS (If rural, give location): 2502 Sycamore Ave.

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 2-14-04

9. AGE (In years last birthday): 62

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Henry Copeland

14. MOTHER'S MAIDEN NAME: Charlotte Hill

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-07-5809

17. INFORMANT: Daughter

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

120X

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 d.

DUE TO

(B) Metastatic Ca of Breast — 3-64

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 9 1967 to Feb 16 1967, that (I) (we) last saw the deceased alive on Feb 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dean H. Griffin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-16-67

23C. PHYSICIAN'S NAME (Type): Dean H. Griffin M.D.

23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-20-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State): Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: Morton & Dagett

ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530

BIRTH NO. 67 1629

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1629

1. NAME OF DECEASED (Type or Print): Smith - Marion Richardson

2. DATE AND HOUR OF DEATH: 9.00 Am. Feb 15. 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1312 Eutaw Place

11-04

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	Negro	M	07-02-03	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Thomas Young Richardson

14. MOTHER'S MAIDEN NAME: Mary Baden

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-30-2631

17. INFORMANT: Mrs. Dorothea Smith ADDRESS: 1312 N. Eutaw Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 15 hours

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8.55 pm. Feb 14 1967 to 9.00 Am Feb 15 1967, that (I) (we) last saw the deceased alive on 9.00 Am. Feb 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Won Song M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb 15, 1967

23C. PHYSICIAN'S NAME (Type): DR. SANG WON SONG M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	2-18-67	New Cathedral Cem.	Balto.	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 20 1967	[illegible]	Hoffman Dyett F.H.	1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-30d

Released By MED Per. Mr. Wm Henry

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1630

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1630

1. NAME OF DECEASED (Type or Print): James Robert Scott

2. DATE AND HOUR OF DEATH: 2-17-67 | 11 15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13 0 4

D. STREET ADDRESS (If rural, give location): 2906 Parkwood Ave #17

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: April 14, 1891

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hanover Co. VA.

12. CITIZEN OF WHAT COUNTRY? US 77

13. FATHER'S NAME: UNK.

14. MOTHER'S MAIDEN NAME: Susie Brooks

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-3111

17. INFORMANT: Evan Brooks

ADDRESS: RT 1 Box 571 Mechanicville, VA

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I: 199.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Disseminated Malignancy

INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B)

DUE TO (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-17 1967 to 2-17 1967, that (I) (we) last saw the deceased alive on 2-17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Skipkus M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-18-67

23C. PHYSICIAN'S NAME (Type) M.D.:

23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-20-67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Martin Dyott F.H.

ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

1

M-625

67 1631

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65-22949 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 67 1631

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lynn Morgan	2. DATE AND HOUR PRONOUNCED DEAD: 2/17/67 M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Mercy Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: 28-02 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 5505 W. Wesley Dr. Ave

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
female	colored	Child	Sept 13, 1965	1	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child		Balto., Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM A. MORGAN	VERNETTA HOPKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mr. William Morgan	5505 Wesley Avenue

MEDICAL CERTIFICATION

1B. 4242

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy X and that on this basis, death in my opinion resulted from: Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER X
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/18/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2-20-67	Arbutus Mem. Park	Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 20 1967	Robert E. Fahrney	Morton & Dyett F.H.	1701 Laurens St.

3/2/67

VS 151-REV. 1/1/65

67 0 0 1 6 3 1

J-525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1632 Registered No. 67 1632

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elaine Johnson

2. DATE AND HOUR OF DEATH: 2-15-67 8:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 2917 Walbrook Avenue

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1-6-38
9. AGE (In years last birthday): 28 yrs.
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNK
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jessie Reeder
14. MOTHER'S MAIDEN NAME: Nora Reeder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Nora Reeder -mother ADDRESS: 3005 Walbrook Ave.

MEDICAL CERTIFICATION

1B. 581.01

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cirrhosis of Liver
DUE TO
(B) Ruptured Esophageal varices
DUE TO
(C) ~~Bronch~~ Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 26, 1966 to February 15, 1967, that (I) (we) last saw the deceased alive on February 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Laredo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-16-67
23C. PHYSICIAN'S NAME (Type): Dr. C. Laredo M.D.
23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-20-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: Morton R. Digitt ADDRESS: 1701 Lawrence

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-01980 67 1633 Registered No. 67 1633

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): B/G FRANCES MITCHELL

2. DATE AND HOUR OF DEATH: Feb 15 1967 4:05 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 3217 BAKER STREET 21216

16-07

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced (specify))	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	NEGRO	NEVER MARRIED	2-1-67	–	–	14		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HOWARD D. Mitchell

14. MOTHER'S MAIDEN NAME: FRANCES MITCHELL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Frances Watters

ADDRESS: 3620 Fairview Ave.

MEDICAL CERTIFICATION

18. 794.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) SEVERE CONGESTIVE HEART FAILURE	10 DAYS
DUE TO	
(B) CONGENITAL HEART DISEASE	16 DAYS
DUE TO (TOTAL ANOMALOUS PULM. VENOUS RETURN)	(FROM BIRTH)
(C)	

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/14/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CONGENITAL HEART DIS.

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from Feb 8 1967 to Feb 15 1967, that (I) ~~(we)~~ last saw the deceased alive on Feb 15 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Timothy J. Gardner M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb 15, 1967

23C. PHYSICIAN'S NAME (Type): TIMOTHY J. GARDNER M.D.

23D. ADDRESS: THE JOHNSHOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-18-67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Morton & Deyth F.H.

ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

1967000163

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-260

BIRTH NO. 67 1634

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1634

1. NAME OF DECEASED (Type or Print): ROBERT KEYS

2. DATE AND HOUR OF DEATH: FEB 15/67 8:55 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: C
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2019 DIVISION Street

1403

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	C	Single	5-26-26	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Griffin Keys

14. MOTHER'S MAIDEN NAME: Estella Copper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: admission sheet ADDRESS:

MEDICAL CERTIFICATION

1B. 795.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Brain stem anoxia

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 25 1967 to Feb 15 1967, that (I) (we) last saw the deceased alive on Feb 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rodrigo Toro M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb 15/67

23C. PHYSICIAN'S NAME (Type): RODRIGO TORO M.D.

23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb 20/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: V. Brooke Ruggold

ADDRESS: 1463 N. Carey St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

D-163

BIRTH NO. 67 1635

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1635

1. NAME OF DECEASED (Type or Print): WILLIAM H. DEFORD

2. DATE AND HOUR PRONOUNCED DEAD: February 16, 1967 7:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1008 Brantley Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01

D. STREET ADDRESS (If rural, give location): 1008 Brantley Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Negro	widower	9-17-1902	64	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm DeFord

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wm DeFord ADDRESS: 717 Appleton St

MEDICAL CERTIFICATION

18. 4221

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/16/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/20/67

23C. NAME of CEMETERY or CREMATORY: Mt Auburn

23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

24B. NAME OF REGISTRAR: Robert E. Faber M.D.

24C. FUNERAL DIRECTOR: Marshall A Hayes ADDRESS: 638 N Gilmor St

VS 151-REV. 1/1

0 0 0 1 6 3 8

D-256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1636 Registered No. 67 1636

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Blanche Dickson

2. DATE AND HOUR OF DEATH: 2-16-67 5:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 2444 McCulloh Street

1303

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 11-23-1884
9. AGE (In years last birthday): 81 yrs.
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James & Vernon - sons
ADDRESS: 2322 Koko Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 15, 1967 to February 16, 1967, that (I) (we) last saw the deceased alive on February 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dr Amini / Dr Laredo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-16-67
23C. PHYSICIAN'S NAME (Type): Dr. Amini / Dr. C. Laredo M.D.
23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 21/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Falkenna
25C. FUNERAL DIRECTOR: V. Brooks Ruggold
ADDRESS: 1463 N. Carey St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-560

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1637 Registered No. 67 1637

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Jack Floyd Monroe

2. DATE AND HOUR OF DEATH: 16 FEB 1967 | 6 35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University of Maryland Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 1014 W. Hollins St

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 10/1/97
9. AGE (In years last birthday): 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Junker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Essex Co. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Monroe
14. MOTHER'S MAIDEN NAME: Nannie Blake

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W.W. 2
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Washington — ADDRESS: 1014 Hollins St.

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Metastatic Adeno-carcinoma
DUE TO
(B) A.S.C.V.D.
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. Wenzel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 16 feb '67
23C. PHYSICIAN'S NAME (Type): Richard P. Wenzel M.D.
23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/21/1967
24C. NAME of CEMETERY or CREMATORY: Balto. National Cem.
24D. LOCATION (City, town or county) (State): Balto, Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Fabiano
25C. FUNERAL DIRECTOR: Williams Funeral Home — ADDRESS: 3197 Schroeder St

VS 150-REV. 1/1965

B-6501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1638 Registered No. 67 1638

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Eugenia Brown.

2. DATE AND HOUR OF DEATH: 2-16-1967 | 1:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 23-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230

D. STREET ADDRESS (If rural, give location): 144 W. Cross Street.

5. SEX: F

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 5/19/22

9. AGE (In years last birthday): 44

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: David Brown ADDRESS: 144 W. Cross St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) INTRACRANIAL HEMORRHAGE (INTRACEREBRAL) — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

DUE TO

(B) HYPERTENSION — PROBABLY SEVERAL YEARS

DUE TO

(C) MARKED OBESITY — SEVERAL YEARS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): YES.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-15 1967 to 2-16 1967, that (I) (we) last saw the deceased alive on 2-16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold A. Burnham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-16-67.

23C. PHYSICIAN'S NAME (Type): Harold A. Burnham M.D.

23D. ADDRESS: 1213 Light Street.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/20/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: Charles A Rice ADDRESS: 661 W Barre St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-2401

BIRTH NO. 67 1639

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1639

1. NAME OF DECEASED (Type or Print): Rosalie Cecil

2. DATE AND HOUR OF DEATH: 2-17-67 | 10:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Little Srs. of The Poor 1200 Valley St Balt Md 21202

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 10-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 9.28.1894

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | (If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Renehan

14. MOTHER'S MAIDEN NAME: Ann Seaman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-28-1082

17. INFORMANT: Little Srs. of The Poor

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) C.V.A

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

331X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1966 to Feb 17 1967, that (I) (we) last saw the deceased alive on Feb 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Arkudas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2.18.67

23C. PHYSICIAN'S NAME (Type): STANLEY ARKUDAS M.D.

23D. ADDRESS: 1101 Maiden Choice Lane Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/20/67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Tarkey M.D.

25C. FUNERAL DIRECTOR: Philip Herwig Sons

ADDRESS: 2024 Orleans St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

e. 6161

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1640

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1640

1. NAME OF DECEASED (Type or Print): CLARENCE CARBERRY

2. DATE AND HOUR OF DEATH: 2/16/67 | 5:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 4413 GROVELAND AVE
B. COUNTY: 28-41
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21215
D. STREET ADDRESS (If rural, give location): MARYLAND

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 1/19/88
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTO. COUNTY
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Thomas Carberry
14. MOTHER'S MAIDEN NAME: Amanda Carberry

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ?
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: CHART
ADDRESS:

MEDICAL CERTIFICATION

18. I 331 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: CEREBROVASCULAR ACCIDENT
INTERVAL BETWEEN ONSET AND DEATH: 10 HOURS

(A) DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/16 19 67 to 2/16 19 67, that (I) (we) last saw the deceased alive on 5:45 PM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Frank M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/16/67
23C. PHYSICIAN'S NAME (Type): SHELDON M. FRANK M.D.
23D. ADDRESS: SINAI HOSPITAL OF MARYLAND

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-20-67
24C. NAME of CEMETERY or CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Faber M.D.
25C. FUNERAL DIRECTOR: Rayner Sanders
ADDRESS: 217 E. Preston St

VS 150-REV. 1/1/65

GG 48-46-99

$5.00

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1641 Registered No. 67 1641

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John D Shawen

2. DATE AND HOUR OF DEATH: 2-14-67 1:20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Avenue #21224 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: A.A. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pasadena

D. STREET ADDRESS (If rural, give location): 62 Juniper Hole Rd.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: 6-4-94

9. AGE (In years last birthday): 72

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John

14. MOTHER'S MAIDEN NAME: Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Vernon R. Leonard-1243 Oakland Terr. Rd. ADDRESS

RECORDS: BCH 4940 Eastern Ave. #21224

MEDICAL CERTIFICATION

18. I — CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular Arrest

DUE TO

(B) Antecedent Cause

DUE TO

(C) Coin Lesion of Lung.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia 1 month prior to death

19A. DATE OF OPERATION: 2-9-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Scalene node biopsy-coin lesion of lung

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): None

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? None

22. I certify that (I) (this hospital) attended the deceased from 1-9- 1967 to 2-14 1967, that (I) (we) last saw the deceased alive on 2-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Charles B. Beckman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): Charles B. Beckman M.D.

23D. ADDRESS: 6116 E. Pratt Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-20-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: [illegible] M.D.

25C. FUNERAL DIRECTOR: Witzke F.D.-4101 Edmondson Ave. ADDRESS

6744

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Charles B. Beckman 6116 E. North Street

W.5 60 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1642

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1642

1. NAME OF DECEASED (Type or Print): Christina Wehner

2. DATE AND HOUR OF DEATH: Feb. 16, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4816 Coleherne Road

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: 2804

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 4816 Coleherne Rd.

5. SEX: F

6. RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 10-10-81

9. AGE (In years last birthday): 85

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel Homberg

14. MOTHER'S MAIDEN NAME: Barbara Friday

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Marie H. Wehner ADDRESS: 4816 Coleherne Rd. - 21229

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Arteriosclerotic CVD. — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 1967 to Feb 16 1967, that (I) (we) last saw the deceased alive on 2/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J C Pound M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/17/67

23C. PHYSICIAN'S NAME (Type): John C. Pound, M.D.

23D. ADDRESS: 3325 Frederick Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-18-67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: [illegible] M.D.

25C. FUNERAL DIRECTOR: Witzke F.D. - 4101 Edmondson Ave. ADDRESS

1645

VS 150-REV. 1/1/65

G/616 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1643 Registered No. 67 1643

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Eleanor L. Greaver

2. DATE AND HOUR OF DEATH: Feb. 18, 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gen. German Aged Home 22 S. Athol Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore 2804

C. CITY OR TOWN (If outside city limits, write RURAL and give township):

D. STREET ADDRESS (If rural, give location): 22 S. Athol Ave.

5. SEX: F

6. RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 1-29-87

9. AGE (In years last birthday): 80

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10B. KIND OF BUSINESS OR INDUSTRY: Goodwill Industries

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late - Charles H. Greaver

14. MOTHER'S MAIDEN NAME: Mary H.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Gen. German Aged Home 22 S. Athol Ave. ADDRESS

MEDICAL CERTIFICATION

1B. 430.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Dehydration & Malnutrition

(B) DUE TO Senility due to generalized

(C) DUE TO arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 19 66 to 18 Feb 19 67, that (I) (we) last saw the deceased alive on 18 Feb 67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William J. Bryson M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 18 Feb 67

23C. PHYSICIAN'S NAME (Type): William J. Bryson M.D.

23D. ADDRESS: 4605 Edmondson Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-21-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Talley M.D.

25C. FUNERAL DIRECTOR: Witzke F.D. - 4101 Edmondson Ave. ADDRESS

VS 150-REV. 1/1/65

0 1 5 7 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C. 5/6

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1644 Registered No. 67 1644

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HERBERT S. CHAMBERS

2. DATE AND HOUR PRONOUNCED DEAD: February 17, 1967 8:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 914 St. Barnabas Ct.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1701
D. STREET ADDRESS (If rural, give location): 914 St. Barnabas Ct.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Colored	Single	Feb. 12, 1916	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver		Brunswick, Va.	

13. FATHER'S NAME: Hervin Chambers

14. MOTHER'S MAIDEN NAME: Magnolia Potillo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	218-03-1218	Grace Grade	1817 E. Federal Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE R Breitenecker M.D.

EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.

DATE SIGNED 2/17/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/21/67	Balto National Cem.	Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 20 1967	Robert E. Farley M.D.	Wm C March	928 E. North Ave.

VS 151-REV. 1/1/65

1967000164 7

B-6512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1645 Registered No. 67 1645

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bernie Brunson

2. DATE AND HOUR OF DEATH: 2-19-67 | 5 40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 2814 Keyworth Ave.

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 12-03-07
9. AGE (In years last birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Hester

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Iris Gladden
ADDRESS: 2600 Round Rd Apt 3A

MEDICAL CERTIFICATION

1B. 466 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Multiple Pulmonary Emboli — 11 days
DUE TO

(B) Deep Vein Thrombosis — ?
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 1-31 1967 to 2-19 1967, that I (we) last saw the deceased alive on 2-19 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: Allan S. Rudolph M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-19-67
23C. PHYSICIAN'S NAME (Type): Allan S. Rudolph M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Tafuri M.D.
25C. FUNERAL DIRECTOR: Wm March
ADDRESS: 928 E. North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

0 0 1 6 1 0

K-514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1646 Registered No. 67 1646

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Amy A. Kneiple

2. DATE AND HOUR OF DEATH: 2/17/67 | 3:45 A.M.

CERTIFICATE AMENDED 2-27-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md Gen Hosp Balto. Md.
48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 27-01
D. STREET ADDRESS (If rural, give location): 3220 Berkshire Rd

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 10/30/83
9. AGE (In years last birthday): 83
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANKLIN PIERCE ERHARD ARHARD
14. MOTHER'S MAIDEN NAME: Mary E. Heiter.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 215-48-4933
17. INFORMANT: Mrs. Herbert Corbett ~~Kenneth R Koskenen~~ ADDRESS: 3220 Berkshire Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) C. V. A. — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

(B) A. S. C. V. D.

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/21/66 19 to 2/17 19 67, that (I) (we) last saw the deceased alive on 2/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R Koskenen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/17/67
23C. PHYSICIAN'S NAME (Type): Kenneth R. Koskenen M.D.
23D. ADDRESS: Md Gen Hosp Balto Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: Evergreen Memorial Cem.
24D. LOCATION (City, town, or county) (State): Portsmouth, Va. Norfolk Co.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Fisher M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 2-27-67 M.H.

S-5-136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1647 Registered No. 67 1647

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Sabena S. SNIDER

2. DATE AND HOUR OF DEATH: Feb. 17, 1967 1:15 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2911 Overland Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-02
D. STREET ADDRESS (If rural, give location): 2911 Overland Avenue

5. SEX: female
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): never married
8. DATE OF BIRTH: July 16, 1884
9. AGE (In years last birthday): 82
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Canton, Miss.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Leonard Snider
14. MOTHER'S MAIDEN NAME: Sarah Jane Shaw

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Marion I. Snider ADDRESS: 2911 Overland Ave.

MEDICAL CERTIFICATION

1B. 4201 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Coronary occlusion
(B) DUE TO: Arteriosclerotic C.V.D.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1950 to Feb. 17 1967, that (I) (~~we~~) last saw the deceased alive on Feb 16 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: J. Henry Haase M.D.
M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: FEB 17 1967
23C. PHYSICIAN'S NAME (Type): Dr. J. Henry Haase M.D.
23D. ADDRESS: 2926 E. Cold Spring Lane, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-21-67
24C. NAME of CEMETERY or CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Foxwell
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.--Baltimore, Md.-14 ADDRESS:

VS 150-REV. 1/1/65

1650

C-625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1648 Registered No. 67 1648

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Philip William Carson

2. DATE AND HOUR OF DEATH: 2-15-67. 7:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: ~~Baltimore~~
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214 27-02
D. STREET ADDRESS (If rural, give location): 4520 Weatzel Ave

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 8-17-06
9. AGE (In years last birthday): 60
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor
10B. KIND OF BUSINESS OR INDUSTRY: Gas & Elec. Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles E. Carson
14. MOTHER'S MAIDEN NAME: Mary E. Gibson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-05-2768
17. INFORMANT: Mrs. Ann E. Carson
ADDRESS: (Same)

MEDICAL CERTIFICATION

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Acute Myocardial Infarction — 5 days

(B) DUE TO:

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-10-67 19 67 to 2-15 19 67, that (I) (we) last saw the deceased alive on 2-15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John R. Vaughn Jr M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-15-67
23C. PHYSICIAN'S NAME (Type): JOHN R. VAUGHN, JR M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/18/67
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

165

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-624

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1649 Registered No. 67 1649

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): THOMAS J. DRISCOLL

2. DATE AND HOUR PRONOUNCED DEAD: February 15, 1967 8:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2835 Pelham Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21213 27-01
D. STREET ADDRESS (If rural, give location): 2835 Pelham ~~Street~~ Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: April 27, 1913.
9. AGE (In years last birthday): ~~54~~ 53
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker
10B. KIND OF BUSINESS OR INDUSTRY: Casket Mfgr.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael J. Driscoll
14. MOTHER'S MAIDEN NAME: Ellen ~~M~~ D'Arcy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-03-8662
17. INFORMANT: Mr. William D. Driscoll
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. 422.1 I 260X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Diabetes Mellitus

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/15/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/18/67.
23C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 151-REV. 1/1/65

1967 0001652

R-52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1650 Registered No. 67 1650

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William C. Runge

2. DATE AND HOUR OF DEATH: 2-15-1967 | 6:00 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gould Convalescarium 6116 Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-34
D. STREET ADDRESS (If rural, give location): 6116 Belair Road

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Nov. 3, 1889.
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Power Plant Designer
10B. KIND OF BUSINESS OR INDUSTRY: Gas & Elec. Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Runge
14. MOTHER'S MAIDEN NAME: Mathilda Luthardt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-05-6665
17. INFORMANT: Mr. Gordon R. Runge, ADDRESS: 534 Brook Rd. Balto. #4

MEDICAL CERTIFICATION

18. I 420.1 + 153.8

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial infarction — Immediate
DUE TO
(B) Arteriosclerotic cardiovascular disease — 10 years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Carcinoma of colon — 2 years

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 19 67 to February 15 19 67, that (I) (~~we~~) last saw the deceased alive on February 13 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: A. Allan Spier M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): A. Allan Spier M.D.
23D. ADDRESS: 1501 Pentridge Road.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/17/67.
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-100

BIRTH NO. 67 1651

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1651

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): SAMUEL GRUVER HOFF

2. DATE AND HOUR OF DEATH: 2-15-67 10:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL 44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 27-44
D. STREET ADDRESS (If rural, give location): 5909 BERTRAM AVE.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 11-09-90
9. AGE (In years last birthday): 76
If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Electrical Engineer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SAMUEL S. HOFF
14. MOTHER'S MAIDEN NAME: FLORENCE A. UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): ~~XXXX~~ No
16. SOCIAL SECURITY NO. 213-01-0185A
17. INFORMANT: CHART
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Retroperitoneal Hemorrhage
DUE TO
(B) Ruptured Arteriosclerotic abdominal aortic aneurysm.
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-13 1967 to 2-15 1967, that (I) ~~(we)~~ last saw the deceased alive on 2-15 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Frank A. Carozza M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-15-67
23C. PHYSICIAN'S NAME (Type): FRANK A. CAROZZA M.D.
23D. ADDRESS: UNION MEMORIAL HOSPITAL
THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/18/67.
24C. NAME of CEMETERY or CREMATORY: Holsinger Cemetery
24D. LOCATION (City, town, or county) (State): Bloomfield Township, Pa.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Lasky, M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS:

VS 150-REV. 1/1/65

1 6 7 0 0 0 1 6 5 1

E-2516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1652 Registered No. 67 1652

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAGDALENA EGNER

2. DATE AND HOUR OF DEATH: February 16, 1967. 2:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hood Convalescent Home 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #28 53-00

D. STREET ADDRESS (If rural, give location): 292 Bloomsbury Ave.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: April 8, 1874.

9. AGE (In years last birthday): 92

If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Examiner

10B. KIND OF BUSINESS OR INDUSTRY: Clothing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Egner

14. MOTHER'S MAIDEN NAME: Rosina Leidig

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-05-9442A

17. INFORMANT: Mrs. Catherine Schadbach, 5114 Crosswood Ave. ADDRESS

MEDICAL CERTIFICATION

1B. 157X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Dehydration & Malnutrition

DUE TO

(B) Obstructive Jaundice

DUE TO

(C) Carcinoma of pancreas

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1966 to 16 Feb 1967, that (I) (we) last saw the deceased alive on 16 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William J. Bryson M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 16 Feb 67

23C. PHYSICIAN'S NAME (Type): William J. Bryson M.D.

23D. ADDRESS: 4605 Edmondson Ave Balto 29 Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/20/67.

24C. NAME of CEMETERY or CREMATORY: Western Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

0655

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1653 | Registered No. 67 1653

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EMILY NAOMI DISNEY

2. DATE AND HOUR OF DEATH: Feb 17 1967 | 2:35 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Long Green Nursing Home Melrose Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): (RODGERS FORGE) TOWSON 21212
D. STREET ADDRESS (If rural, give location): 249 Rodgers Forge Road 53-00

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: Nov. 8, 1889
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Bendix
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Wendall Amos Smith
14. MOTHER'S MAIDEN NAME: Katherine Armistedd Arnold

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-20-1891
17. INFORMANT: Son
ADDRESS: LeRoy R. Disney, 249 Rodgers Forge Rd., 21212

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

DUE TO

(B) Arterial hypertension — 15+ yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Oct 30 1953 to Feb 17 1967, that (I) (~~we~~) last saw the deceased alive on Feb 17 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Frederick J. Vollmer M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Feb 17, 1967
23C. PHYSICIAN'S NAME (Type): FREDERICK J VOLLMER M.D.
23D. ADDRESS: 6100 YORK RD, BALTIMORE, MD 21212

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 20, 67
24C. NAME of CEMETERY or CREMATORY: Trinity M.E. Church Cem.
24D. LOCATION (City, town, or county) (State): Patuxent, A. A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Stewart & Bowen Co.
ADDRESS: 108 W. North Av., City

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

D. 2501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1653 Registered No. 67 1653

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EMILY NAOMI DISNEY

2. DATE AND HOUR OF DEATH: Feb. 17, 1967 | 2:35 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Long Green Nursing Home Melrose Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): (RODGERS FORGE) TOWSON 21212
D. STREET ADDRESS (If rural, give location): 249 Rodgers Forge Road

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: Nov. 8, 1889
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Bendix
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Wendall Amos Smith
14. MOTHER'S MAIDEN NAME: Katherine Armistead Arnold

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-20-1891
17. INFORMANT: Son
ADDRESS: 21212
LeRoy R. Disney, 249 Rodgers Forge, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 443 X

(A) Arteriasclerotic Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years

DUE TO

(B) Arterial hypertension — 15 years

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from October 30 19 53 to February 17 19 67, that (I) (we) last saw the deceased alive on February 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frederick T. Vollmer M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Feb. 17,1967
23C. PHYSICIAN'S NAME (Type): Frederick T. Vollmer M.D.
23D. ADDRESS: 6100 York Rd., Baltimore, Md. 21212

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 20,67
24C. NAME of CEMETERY or CREMATORY: Trinity M.B.Church Cemetery
24D. LOCATION (City, town, or county) (State): Patuxent, A.A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: Stewart & Mowen Co.,
ADDRESS: 108 W. North Ave., City

1656

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1651 Registered No. 67 1651

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Luck Waldo L.

2. DATE AND HOUR OF DEATH: 2/16/67 6:00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: Baltimore Md. 21216

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 3701 Forest Park Ave 15-38

D. STREET ADDRESS (If rural, give location):

5. SEX: Male

6. RACE: Negro

7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)): MARRIED

8. DATE OF BIRTH: 11-09-00

9. AGE (In years last birthday): 66 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PRESTON LUCK

14. MOTHER'S MAIDEN NAME: AMANDA HOGUE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: HAZEL M. LUCK — ADDRESS: 1230 MARYLAND AVENUE, N.E.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MI, CVA

DUE TO

(B) Pneumonia

DUE TO

(C) ASCVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 1 1967 to Feb 16 1967, that (I) (we) last saw the deceased alive on Feb 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F. Ismail Beigi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): F. ISMAIL BEIGI M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-21-1967

24C. NAME of CEMETERY or CREMATORY: HARMONY

24D. LOCATION (City, town, or county) (State): LANDOVER, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Taylor

25C. FUNERAL DIRECTOR: WERNEST JARVIS CO. ADDRESS: 1438 You Street, N.W.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-07-17
IW

355

BIRTH NO. 67 1655

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1655

1. NAME OF DECEASED (Type or Print): GENEVA GOODMAN

2. DATE AND HOUR OF DEATH: 2/15/67 5 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 3326 VIRGINIA AVENUE - 21215

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 10/10/00

9. AGE (In years last birthday): 66

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: TONY MCFADDEN

14. MOTHER'S MAIDEN NAME: CAROLINE MCKNIGHT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224

ADDRESS:

MEDICAL CERTIFICATION

18. 199.20

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) PULMONARY EMBOLUS

DUE TO

(B)

DUE TO

(C) CANCER

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/19 1966 to 2/15 1967, that (I) (we) last saw the deceased alive on 2/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Phillip L. Hall M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/15/67

23C. PHYSICIAN'S NAME (Type): PHILLIP L. HALL M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-20-66

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Gilroy E. Gibson

ADDRESS: 1000 Brently St

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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V-600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1656 Registered No. 67 1656

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES E. TERRY

2. DATE AND HOUR PRONOUNCED DEAD: February 15, 1967 8:55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 728 Ensor Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-02
D. STREET ADDRESS (If rural, give location): 728 Ensor Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 10-15-1906
9. AGE (In years last birthday): 62
If Under 1 Yr. or Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Henderson N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Terry
14. MOTHER'S MAIDEN NAME: Mary E. Batthys

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): YES
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary Rogal ADDRESS: 4306 Berryhill Ave.

MEDICAL CERTIFICATION

18. 4200 I
CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/16/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-23-67
23C. NAME of CEMETERY or CREMATORY: Balt Nat Cem
23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
24B. NAME OF REGISTRAR: Ralph E. Farber M.D.
24C. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave

VS 151-REV. 1/1/65

1967 0001652

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E-400

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1657 Registered No. 67 1657

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DAVID EUGENE ELEY

2. DATE AND HOUR PRONOUNCED DEAD: February 15, 1967 6:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-48
D. STREET ADDRESS (If rural, give location): 2306 Roslyn Avenue

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): single
8. DATE OF BIRTH: Sept 28-1926
9. AGE (In years last birthday): 41
If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eugene D. Eley Sr
14. MOTHER'S MAIDEN NAME: Elizabeth Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. E 812.4

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Multiple Traumatic Injuries.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Balto. Beltway, S. of Md. 144

21D. TIME OF INJURY (APPROX.) (Month) 2 (Day) 12 (Year) '67 (Hour) P m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto 53-00

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/16/67

23A. BURIAL CREMATION, REMOVAL (Specify): burial
23B. DATE: 2-21-67
23C. NAME of CEMETERY or CREMATORY: Mt Cabary Cem
23D. LOCATION (City, town, or county) (State): Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: Elroy C Wilson
ADDRESS: 100 Brantley Ave

VS 151-REV. 1/1/65

N 67 92 7 0 0 1 6 6 0

G-300

67 1658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1658

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): GOODE CORA

2. DATE AND HOUR OF DEATH: February 18-1967 10.45 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hosp. 46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16-07
D. STREET ADDRESS (If rural, give location): 3006 PRESSTMAN St. #16

5. SEX: FEM.
6. RACE: NEG.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: Oct 1898
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: George Wilson
14. MOTHER'S MAIDEN NAME: Minnie Rutledge
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Russell Dyroche — ADDRESS: Same

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X + 260X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hemiplegia - BRAIN DAMAGE — 3 MONTH

DUE TO

(B) ASHCVD - DIABETES MELLITUS — FEW YEARS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov - 28 1966 to Feb. 18 1967, that (I) (we) last saw the deceased alive on Feb. 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-18-1967
23C. PHYSICIAN'S NAME (Type): [illegible]
23D. ADDRESS M.D.: 2519 GATE HOUSE DR. BALTO. 21207

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-20-67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE RECD BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Elroy A. Wilson — ADDRESS: 1010 Bennett Ave

VS 150-REV. 1/1/65

1967 00 1661

J-526

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1659 — Registered No. 67 1659

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Nellie B Jones

2. DATE AND HOUR OF DEATH: 2-19-67 | 9:00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1103 N. MILTON AVE.

S-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	NEGROID	WIDOWED	1-1-04	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BERRY YOUNG
14. MOTHER'S MAIDEN NAME: ADDIE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ahuta Jones — ADDRESS:

MEDICAL CERTIFICATION

1B. 581.0

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Chronic active hepatitis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/8/67 19 67 to 2/19 19 67, that (I) (we) last saw the deceased alive on 2/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sherrard Hayes M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/19/67
23C. PHYSICIAN'S NAME (Type): Sherrard Hayes M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-24-67
24C. NAME of CEMETERY or CREMATORY: St Jones Cem N.C.
24D. LOCATION (City, town, or county) (State): North Carolina

25A. DATE RECEIVED BY REGISTRAR: FEB 20 1967
25B. NAME OF REGISTRAR: Louis L. Tarlow M.D.
25C. FUNERAL DIRECTOR: Ethney O. Wilson — ADDRESS: 1000 Brentley Ave.

VS 150-REV. 1/1/65

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F-654

67 1660

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1660

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY Agnes FARNELL

2. DATE AND HOUR PRONOUNCED DEAD: February 17, 1967 | 11:50 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 3422 DuPont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16

D. STREET ADDRESS (If rural, give location): 3422 DuPont Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: April 23, 1920

9. AGE (In years last birthday): 46

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10B. KIND OF BUSINESS OR INDUSTRY: Sinai Hospital

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Christopher

14. MOTHER'S MAIDEN NAME: Rebecca

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Robert E. Farnell

ADDRESS: same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E874.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Overdose of Doriden

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3422 DuPont Avenue 27-16

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): Approx. 2/17/67 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR?: Apparent overdose.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [X]

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 2/17/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/20/1967

23C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery

23D. LOCATION (City, town, or county) (State): Pikesville, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

24B. NAME OF REGISTRAR: Robert E. Farnell

24C. FUNERAL DIRECTOR: Wm. J. Tilghman & Sons

ADDRESS: Balto., Md. North Ave.

VS 151-REV. 1/1/65

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A-350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1661 Registered No. 67 1661

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Oliver Auodoun

2. DATE AND HOUR OF DEATH: February 18, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3409 Milford Avenue Baltimore, Maryland 21207

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-02

D. STREET ADDRESS (If rural, give location): 3409 Milford Avenue 21207

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: June 21, 1897

9. AGE (In years last birthday): 69

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Purchasing Agent

10B. KIND OF BUSINESS OR INDUSTRY: Kelsch Insurance Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Oliver W. Auodoun

14. MOTHER'S MAIDEN NAME: Mary Thirlkeld

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 220-12-9150

17. INFORMANT: Mrs. Bertha S. Auodoun

ADDRESS: same address

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — 10 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Oct. 1959 to Feb. 18, 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 17, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Marvin Goldstein M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): MARVIN GOLDSTEIN M.D.

23D. ADDRESS: 6001 PARK HEIGHTS AVE. BALTO., MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/1967

24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery

24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR: Wm. J. Tilmon & Sons with L.P.A.

ADDRESS: Balto., Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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F-52

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1662

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1662

1. NAME OF DECEASED (Type or Print): Hugh W. Feemster

2. DATE AND HOUR OF DEATH: February 19, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): House-in-the-Pines - Belvedere

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-11
D. STREET ADDRESS (If rural, give location): 4546 North Charles Street 10

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: April 17, 1877
9. AGE (In years last birthday): 89
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager - Retired
10B. KIND OF BUSINESS OR INDUSTRY: Western Md. R R
11. BIRTHPLACE (State or foreign country): Greenville, Tenn.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Paul S. Feemster
14. MOTHER'S MAIDEN NAME: Belle Wilson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. D. H. Feemster
ADDRESS: same address

MEDICAL CERTIFICATION

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Infarct — 1 d
DUE TO Hypertensive Arteriosclerotic CVD — 10 y
(B) Deafness — ?
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 25 19 63 to 2/19/67 19 , that (I) (we) last saw the deceased alive on 2/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lester N. Kolman M.D. — Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/20/67
23C. PHYSICIAN'S NAME (Type): LESTER N. KOLMAN, M.D. M.D.
23D. ADDRESS: 3900 Park Heights Avenue 21215

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/1967
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Wm. J. Tickner & Sons
ADDRESS: Baltimore, Md. [illegible]

VS 150-REV. 1/1/65

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B-653

BIRTH NO. 67 1663

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1663

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Bryant, Henry Ray Jr.

2. DATE AND HOUR OF DEATH: February 19, 1967 | 3:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital
27 3900 Loch Raven Blvd.
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Richmond V-43
D. STREET ADDRESS (If rural, give location): 3129 Rosewood Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 9/23/26
9. AGE (In years last birthday): 40
If Under 1 Yr. Months: Days | If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beef Boner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Henry Roy Bryant Sr.
14. MOTHER'S MAIDEN NAME: Pearl Skinner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 2/17/44-5/6/46
16. SOCIAL SECURITY NO.: 225-20-29-94
17. INFORMANT: Veterans Hospital Records, Balto., Md.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 10 Days
DUE TO
(B) CIRRHOSIS OF LIVER
DUE TO
(C) ALCOHOLISM

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 16, 1967 to February 19, 1967, that (I) (we) last saw the deceased alive on February 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Jay Block M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/19/67
23C. PHYSICIAN'S NAME (Type): James Block M.D.
23D. ADDRESS: Veterans Hospital, Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 2/20/1967
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): Richmond, Virginia

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Foley M.D.
25C. FUNERAL DIRECTOR: Wm. J. Tickner & Son
ADDRESS: Balto. md. North Ave.

VS 150-REV. 1/1/65

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BIRTH NO. 67 1664

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1664

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ELLA C. PETERS

2. DATE AND HOUR OF DEATH: February 19, 1967. 3:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(If not in hospital or institution, give street address or location): 6508 Moyer Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-05
D. STREET ADDRESS (If rural, give location): 6508 Moyer Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Feb. 11, 1880.
9. AGE (In years last birthday): 87
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Burns
14. MOTHER'S MAIDEN NAME: Elizabeth Keller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 215-56-6254
17. INFORMANT: Mrs. Katheryn P. Carter
ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Myocardial infarction — 10 days
DUE TO
(B) Generalized arteriosclerosis — 7 years
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 10 1967 to Feb 19 1967, that (I) (we) last saw the deceased alive on Feb 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Richard Fravel M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/19/67
23C. PHYSICIAN'S NAME (Type): Richard Fravel M.D.
23D. ADDRESS: 705 Medical Arts Baltimore Md 21201

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/67.
24C. NAME of CEMETERY or CREMATORY: Etam Methodist Cemetery
24D. LOCATION (City, town, or county) (State): Etam, West Virginia.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Leonard J. Buck, Inc.
ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

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V-640

BIRTH NO. 67 1665

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1665

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANK D. ~~XXXXXXX~~ VARELLA

2. DATE AND HOUR PRONOUNCED DEAD: February 16, 1967 9:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 2715 Huntingdon Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: June 13, 1921.
9. AGE (In years last birthday): 45
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10B. KIND OF BUSINESS OR INDUSTRY: Can Company
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nicholas Varella
14. MOTHER'S MAIDEN NAME: Angelina LaViola

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W 2
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Rosina Morgan, ADDRESS: 2810 Westfield Ave. #14

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/17/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/21/67.
23C. NAME of CEMETERY or CREMATORY: Lake View Mem. Cemetery
23D. LOCATION (City, town, or county) (State): Sykesville, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
24B. NAME OF REGISTRAR: Robert E. Faber M.D.
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 151-REV. 1/1/65

67 0 0 0 1 6 6 8

M-246

BIRTH NO. 67 1666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 67 1666

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) McElroy, Joseph W. McElroy, Joseph

2. DATE AND HOUR OF DEATH 2-18-67 12 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

48 Maryland Gen Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md B. COUNTY Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21204 53-00

D. STREET ADDRESS (If rural, give location) 153 Stevenson Lane

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	M	1/24/11	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Life Insurance Sales	Balto Md	USA

13. FATHER'S NAME John McElroy

14. MOTHER'S MAIDEN NAME Lee Balto.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unk.		218-07-9667	Kent	

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Respiratory obstruction

DUE TO

(B) Ca. of the lung, Rt.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/14 1967 to 2/18/ 1967, that (I) (we) last saw the deceased alive on 2/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE David Cullman MD M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 2/18/67

23C. PHYSICIAN'S NAME (Type) Daniel C. Wilkerson M.D.

23D. ADDRESS 421 Register ave.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/24/67.	Moreland Memorial Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 20 1967	Robert E. Farber M.D.	F. R. CUCK INC.	Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1667 Registered No. 67 1667

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOKEMEYER, HENRY W., JR.

2. DATE AND HOUR OF DEATH: 18 Feb. 67 | 11 25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-07
D. STREET ADDRESS (If rural, give location): 2828 ROSALIE AVE.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 03-08-06
9. AGE (In years last birthday): 60
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTER
10B. KIND OF BUSINESS OR INDUSTRY: PORT CITY PRESS
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY W. HOKEMEYER Sr.
14. MOTHER'S MAIDEN NAME: BERTHA WALTERS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-01-3392
17. INFORMANT: Mrs. Ethel A. Hokemeyer
ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION

DUE TO CORONARY THROMBOSIS

(B) ~~[illegible]~~

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ~~[illegible]~~

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from Jan 29 1967 to Feb 18 1967, that ~~(I)~~ (we) last saw the deceased alive on Feb 18 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Sidney E. Kelly M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 18 Feb 67
23C. PHYSICIAN'S NAME (Type): M.D.
23D. ADDRESS: Union Memorial Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/21/67
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Pk.
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Foulke M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc.
ADDRESS: Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7800670

W-251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1668 Registered No. 67 1668

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CONRAD WAGNER

2. DATE AND HOUR OF DEATH: Feb. 18, 1967 | 4 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3006 Bayonne Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Ma ryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214 2744

D. STREET ADDRESS (If rural, give location): 3006 Bayonne Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Oct. 24, 1880

9. AGE (In years last birthday): 86

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retail grocer-retired

10B. KIND OF BUSINESS OR INDUSTRY: green grocer

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Wagner

14. MOTHER'S MAIDEN NAME: Elizabeth?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-03-2538

17. INFORMANT: Miss Veronica Wagner

ADDRESS: --3006 Bayonne Ave., Balt

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4428 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular Renal Disease — 7 Years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1934 19 to 2-18-67 19, that (I) (~~we~~) last saw the deceased alive on 2-9-67 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: C. W. Peake M. D. — M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/18/67.

23C. PHYSICIAN'S NAME (Type): Dr. C. W. Peake M.D.

23D. ADDRESS: 4508 Harford Rd., Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/67.

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: - Baltimore, Md. - 14

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

36-17-92 I

B-630

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1669

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Beard, Charles W.

2. DATE AND HOUR OF DEATH: 2-18-67 | 4 40 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

26-05

D. STREET ADDRESS (If rural, give location): 508 S. SAVAGE ST. #21224

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-8-97

9. AGE (In years last birthday): 70

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Traffic Mgr.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Beard

14. MOTHER'S MAIDEN NAME: Grace Roberts

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-03-2538

17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE

ADDRESS: #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-8-66 19 to 2-18 19 67, that (I) (we) last saw the deceased alive on 2-18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. Krueger M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-18-67

23C. PHYSICIAN'S NAME (Type): R. Krueger M.D.

23D. ADDRESS: Balt. City Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/67.

24C. NAME of CEMETERY or CREMATORY: Oaklawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

VS 150-REV. 1/1/65

0 1 6 7 9

A-450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1670 Registered No. 67 1670

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Allen, Arthur Taylor

2. DATE AND HOUR OF DEATH: 7.20 pm Feb 16. 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Thellmion Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-08

D. STREET ADDRESS (If rural, give location): 3602 Buena Vista Ave

5. SEX: M

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 8.5.95

9. AGE (In years last birthday): 71

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY: Moving & Storaging

11. BIRTHPLACE (State or foreign country): VA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Allen

14. MOTHER'S MAIDEN NAME: Lean V. Hawkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-10-0237

17. INFORMANT: Margaret Allen ADDRESS: 3602 Buena Vista Ave

MEDICAL CERTIFICATION

1B. 1277X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma of Prostate gland

DUE TO

(B) Cardiac Arrest.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6.35 pm Feb 16 1967 to 7.40 pm Feb 16 1967, that (I) (we) last saw the deceased alive on 7.40 pm Feb 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Won Song M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb. 16. 1967.

23C. PHYSICIAN'S NAME (Type): SANG WON SONG. M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21-67

24C. NAME of CEMETERY or CREMATORY: Moreland Memorial

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fairbanks

25C. FUNERAL DIRECTOR: Frank H. Seitz ADDRESS: 814 W 36 St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1671 Registered No. 67 1671

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Florence Irene Mules

2. DATE AND HOUR OF DEATH: Feb 16, 1967 | 5:45 Pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2503 Barclay Street Baltimore, Md.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12.03

D. STREET ADDRESS (If rural, give location): 2503 Barclay

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	White	Never Married	Jan. 8, 1881	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cashier	Moving Picture House	Maryland	U.S.A

13. FATHER'S NAME: Nathanial Mules

14. MOTHER'S MAIDEN NAME: Purden

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Nellie Litzinger ADDRESS: 1104 Roland Heights Ave

MEDICAL CERTIFICATION

I

1B. 450.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) generalized arteriosclerosis several yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-21- 1966 to Feb. 16 1967, that (I) (we) last saw the deceased alive on Feb. 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E Ellsworth Cook M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2-17-67-

23C. PHYSICIAN'S NAME (Type): E. Ellsworth Cook M.D.

23D. ADDRESS: 2431 Maryland Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Feb 20, 1967	Mt. Olivet Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 20 1967	Robert E. Falkenhan	Frank W Seitz	814 W 36th St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-300

BIRTH NO. 67 1672

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1672

1. NAME OF DECEASED (Type or Print): Samuel Stewart Veit

2. DATE AND HOUR OF DEATH: 2/19/67 | 9:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY: Carroll Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Mt. Airy 56-00

D. STREET ADDRESS (If rural, give location): Watersville Rd.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 5/3/06

9. AGE (In years last birthday): 60

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service MANAGER

10B. KIND OF BUSINESS OR INDUSTRY: Fuel Oil Div.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry H. Veit

14. MOTHER'S MAIDEN NAME: Margaret Bell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-05-8455

17. INFORMANT: LAURA E. Veit - Same

ADDRESS

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebrovascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 16 1967 to Feb. 19 1967, that (I) (we) last saw the deceased alive on Feb 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. M. Morris, M.D. M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/19/67

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-22-67

24C. NAME of CEMETERY or CREMATORY: Poplar Spring Meth Church Cemetery

24D. LOCATION (City, town, or county) (State): Poplar Springs, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNEERAL DIRECTOR: Ellsworth Armacost

ADDRESS: 4600 Liberty Heights Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1673 Registered No. 67 1673

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CARRIE L. SCHINDLER

2. DATE AND HOUR OF DEATH: FEB. 17 1967 9:30 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 ~~XXXX~~ 3601 Garrison Blvd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-10

D. STREET ADDRESS (If rural, give location): 3601 Garrison Blvd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	5-26-1880	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Baltimore	USA

13. FATHER'S NAME: Martin Va Buren Lancaster

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		NONE	Bessie Lancaster	3601 Garrison Blvd.

MEDICAL CERTIFICATION

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 22 years

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Feb. 1 1959 to Feb. 17 1967, that (I) (~~we~~) last saw the deceased alive on Jan. 30 1967 and that In (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Abraham B. Hurwitz M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb. 17 1967

23C. PHYSICIAN'S NAME (Type): ABRAHAM B. HURWITZ M.D.

23D. ADDRESS: 7501 Liberty Road, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-20-1967	Loudon Park Cemetery	Baltimore. Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 20 1967	Robert E. Fogleman	Ellsworth Truscott	4600 Liberty Hghts. Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Unknown

Jan. 30, 67 Feb. 1, 59 Feb. 17, 67

M. L. Hurwitz Feb. 17, 1967

W 4512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1674 Registered No. 67 1674

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edward Carl [redacted] Williams

2. DATE AND HOUR OF DEATH: 2/15/67 8:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital, 601 N. Broadway, Baltimore, Maryland 21205

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Anne Arundel Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Annapolis 52-10

D. STREET ADDRESS (If rural, give location): 38 Parole Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 8/5/1895

9. AGE (In years last birthday): 71 yrs

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): chef cook

10B. KIND OF BUSINESS OR INDUSTRY: ********

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Williams, John L.

14. MOTHER'S MAIDEN NAME: Reed, Anna

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): ********

16. SOCIAL SECURITY NO.: 010-14-7746

17. INFORMANT: Ophelia Barnett ADDRESS: 38 Parole St. Annapolis Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 150X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Ingestion — INTERVAL BETWEEN ONSET AND DEATH: >3 mos

DUE TO

(B) Obstructive Carcinoma of esophagus — >3 mos

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ~~Feb~~ Dec 27 1966 to 2/15 1967, that (I) (we) last saw the deceased alive on February 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. L. Horwitz M.D. Attending Phys. ☐ Med. Director ☐ House Staff Phys. ✓

23B. DATE SIGNED: 2/15/67

23C. PHYSICIAN'S NAME (Type): Richard L. Horwitz M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/18/67

24C. NAME of CEMETERY or CREMATORY: Pine Lawn

24D. LOCATION (City, town, or county) (State): Annapolis Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: C.E. Hicks, 111 Annapolis, Md ADDRESS

1677

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1675 Registered No. 67 1675

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HITZELBERGER, VIRGINIA C

2. DATE AND HOUR OF DEATH: FEBRUARY 15, 1967 | 8:20 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL
CATON AND WILKENS AVENUES
BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 21227 Balt. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 2824 TENNESSEE AVENUE

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 3-28-86
9. AGE (In years last birthday): 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES HILL DEC'D
14. MOTHER'S MAIDEN NAME: FIFTHIAN HILL DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217 09 5618
17. INFORMANT: HOSPITAL SLIP-ST. AGNES HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thyroiditis

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 10, 19 67 to FEBRUARY 15, 19 67, that (I (X) we) last saw the deceased alive on FEBRUARY 15, 19 67 and that in (my) (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) XXXX view the body after death.

23A. SIGNATURE: George S. Patrick M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. (X)
23B. DATE SIGNED: 2-16-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: MXG MT. OLIVET CEM.
24D. LOCATION (City, town, or county) (State): BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Jackson
25C. FUNERAL DIRECTOR: HOWARD H. HUBBARD ADDRESS: 4107 WILKENS AVE. 21229

VS 150-REV. 1/1/65

1670

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-63

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 1676

Registered No.

BIRTH NO. 67-01548

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABY GIRL GARRITY

2. DATE AND HOUR OF DEATH: Feb 16, 1967 4:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD B. COUNTY: BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 18-03

D. STREET ADDRESS (If rural, give location): 2701 ST PAUL STREET 21218

44

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	CHILD	1/23/67	—	0	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS J. GARRITY

14. MOTHER'S MAIDEN NAME: NATALIE SWANSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: J. ALMAND ADDRESS: UNION MEMORIAL HOSP

MEDICAL CERTIFICATION

18. 763X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac arrest — 1 hr

DUE TO

(B) Pneumonia — 19 days

DUE TO

(C) Prematurity (27 weeks - 2 lb 7 oz) 24 days

Autopsy: atelectasis, lt. lower lobe.

U.K. Bird.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 1 1967 to Feb. 16 1967, that (I) (we) last saw the deceased alive on Feb 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Gerald J. Yecies M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Feb 16, 1967

23C. PHYSICIAN'S NAME (Type): JEROLD J. YECIES M.D.

23D. ADDRESS: UNION MEMORIAL HOSP

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/17/1967

24C. NAME of CEMETERY or CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Baltimore 12, Md.

1679

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1677 Registered No. 67 1677

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PROUT, William Leslie

2. DATE AND HOUR OF DEATH: February 16 1967 | 2:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-07

D. STREET ADDRESS (If rural, give location): 700 W. 40th Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 3/25/83

9. AGE (In years last birthday): 83

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney

10B. KIND OF BUSINESS OR INDUSTRY: Law

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edmund James Prout

14. MOTHER'S MAIDEN NAME: Louisa Ringgold

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): 4/12/17 to 10/14/19

16. SOCIAL SECURITY NO.: 214-34-2675

17. INFORMANT: Records VA, Hospital

ADDRESS: 3900 Loch Raven Blvd. Baltimore, Md. 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 13, 1967 to February 16, 1967, that (I) (we) last saw the deceased alive on February 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louise U. Sultan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/16/67

23C. PHYSICIAN'S NAME (Type): LOUISE U. SULTAN M.D.

23D. ADDRESS: Veterans Administration Hospital, 3900 Loch Raven Blvd. Balto., Md. 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/18/1967

24C. NAME of CEMETERY or CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Woodlawn, Balto.Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Lyle M.D.

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Balto.12, Md.

0 0 1 6 8 0

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1678 Registered No. 67 1678

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rose J. Mussbauer

2. DATE AND HOUR OF DEATH: 18 Feb 67 | 12:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Md. General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: —

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-01

D. STREET ADDRESS (If rural, give location): 4116 The Alameda

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 1/6/71

9. AGE (In years last birthday): 96

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~None~~ HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edgar Mumford

14. MOTHER'S MAIDEN NAME: Charlotte Gunlock

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-10-8927

17. INFORMANT: daughter ADDRESS: MRS. ANNETTE N. CAWLEY 4116 THE ALAMEDA

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASCVD

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-12 1967 to 2-18 1967, that (I) (we) last saw the deceased alive on 2-18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: D. H. Griffin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 18 Feb 67

23C. PHYSICIAN'S NAME (Type): D. H. Griffin M.D.

23D. ADDRESS: Maryland General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/1967

24C. NAME of CEMETERY or CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Woodlawn, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: R. D. B. E. Jenkins M.D.

25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Baltimore 12, Md.

160

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1679 Registered No. 67 1679

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Virginia S. Hurtt

2. DATE AND HOUR OF DEATH: Feb. 16, 1967 | 2:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

713 Highwood Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21212 27-48

D. STREET ADDRESS (If rural, give location): 713 Highwood Drive

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 6/10/1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Agustus Parr

14. MOTHER'S MAIDEN NAME: Rosalie Stevens

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Edmund W. Hurtt, Jr., 2820 Rona Rd. ADDRESS 21207

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio- — 15 yrs.

DUE TO vascular disease

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 19 62 to February 16 19 67, that (I) (~~we~~) last saw the deceased alive on February 9 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb. 17, 1967

23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.

23D. ADDRESS: 3902 Greenmount Ave.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/18/1967

24C. NAME of CEMETERY or CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Woodlawn, Balto.Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Parker M.D.

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto. 12, Md.

0 1 6 0 2

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-5210

BIRTH NO. 67 1680

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1680

1. NAME OF DECEASED (Type or Print): Edna Amos

2. DATE AND HOUR OF DEATH: February 15 1967 | 11:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bolton Hill Nursing Center

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towsonium

53-00

D. STREET ADDRESS (If rural, give location): 14 Gorsuch Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 7/12/84

9. AGE (In years last birthday): 82

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Dryder

14. MOTHER'S MAIDEN NAME: Margaret Gibbons

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 215-54-0842T

17. INFORMANT:

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 194 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Thyroid, metastatic — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 10/27/66 19 to 2/15/67 19, that (I) ~~(we)~~ last saw the deceased alive on 2/6/67 19 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did not) view the body after death.

23A. SIGNATURE: Stanley Z Felsenberg M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/15/67

23C. PHYSICIAN'S NAME (Type): Stanley Z. Felsenberg M.D.

23D. ADDRESS: 1129 E. Baltimore St. Balto. 2, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-18-67

24C. NAME of CEMETERY or CREMATORY: Weisburg, ~~White Hall, Md~~ ~~John Burns' Sons, Towson, Md~~

24D. LOCATION (City, town, or county) (State): White Hall, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Foley M.D.

25C. FUNERAL DIRECTOR: John Burns' Sons, Towson, Md.

ADDRESS:

VS 150-REV. 1/1/65

FEB 20 1967 Robert E. Foley M.D.

1683

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-2 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1681 Registered No. 67 1681

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sister Rose Marie Bousquet

2. DATE AND HOUR OF DEATH: February 18, 1967 3:00 P.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Villa Saint Michael

94

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore City 28-41

D. STREET ADDRESS (If rural, give location): 4000 Forest Hill Road

5. SEX: F.

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): never married

8. DATE OF BIRTH: 9/26/1883

9. AGE (In years last birthday): 83

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse-retired

10B. KIND OF BUSINESS OR INDUSTRY: Sister of Charity

11. BIRTHPLACE (State or foreign country): Grosvenordale, Connecticut

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Oliver Bousquet

14. MOTHER'S MAIDEN NAME: Tarsille Revenelle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-54-0265

17. INFORMANT: Sister Andrea ADDRESS: -same address

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — 1 day

DUE TO

(B) Arteriosclerosis — 3 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 1964 to February 1967, that (I) (we) last saw the deceased alive on February 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb. 18, 1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 33[illegible] Bel[illegible] Rd.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/20/67

24C. NAME of CEMETERY or CREMATORY: Seton - on Grounds of the

24D. LOCATION (City, town, or county) (State): Seton Inst., Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Stewart & Owen Co.,

ADDRESS: 108 W. North Av., City

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

R-500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1682 Registered No. 67 1682

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGARET M RYAN

2. DATE AND HOUR OF DEATH: XXXXXX 2-18-67 7:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST AGNES HOSPITAL WILKENS & CATON BALTIMORE 29 MD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: MARYLAND (SETON INSTITUTE) SINCE 1929
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 28-42
D. STREET ADDRESS (If rural, give location):

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 4 13 87
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TELEPHONE OPER
10B. KIND OF BUSINESS OR INDUSTRY: TELEPHONE
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: WILLIAM RYAN
14. MOTHER'S MAIDEN NAME: ELIZABETH WHITE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215 56 1430
17. INFORMANT: BALTO 29 MD
ADDRESS: ST AGNES HOSP WILKENS & CATON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Gastric ulcers
DUE TO
(B) Sub-dural hematoma
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that I (this hospital) attended the deceased from 2 15 19 67 to 2 17 19 67, that I (we) last saw the deceased alive on 2 17 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) did did not view the body after death.

23A. SIGNATURE: Pablo E. Dibos M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2-18-67
23C. PHYSICIAN'S NAME (Type): PABLO E. DIBOS, M.D.
23D. ADDRESS: ST. AGNES HOSP.-CATON & WILKENS AVE. BALTO., MD. 21229

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/22/1967
24C. NAME of CEMETERY or CREMATORY: St. Mary's Cemetery
24D. LOCATION (City, town, or county) (State): Troy, New York

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Ronald E. Falkenstein
25C. FUNERAL DIRECTOR: Stewart & Mowen Co., 108 W. North Av., City
ADDRESS:

VS 150-REV. 1/1/65

0 1 6 8 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-5413

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1683 Registered No. 67 1683

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Donaldson, Benjamine F, Sr.

2. DATE AND HOUR OF DEATH: 2-13-67 10 20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Parkton - Rural 53-00
D. STREET ADDRESS (If rural, give location): Mt. Carmel Rd.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married.
8. DATE OF BIRTH: 2-13-1902.
9. AGE (In years last birthday): 65
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Farming.
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: David Donaldson.
14. MOTHER'S MAIDEN NAME: May Turnbaugh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): /
16. SOCIAL SECURITY NO.: 21936-1382
17. INFORMANT: Mrs. Cora C. Donaldson, ADDRESS: Parkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Peritonitis - Mass
DUE TO
(B) Perforation of Bowel
DUE TO
(C) Congestive Heart failure

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-26 1967 to 2-13 1967, that (I) (we) last saw the deceased alive on 2-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nabil F Warsal M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-13-67
23C. PHYSICIAN'S NAME (Type): NABIL F. WARSAL M.D.
23D. ADDRESS: Maryland Gen. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Febr. 17 1967
24C. NAME of CEMETERY or CREMATORY: Hereford Methodist Cemetery
24D. LOCATION (City, town, or county) (State): Monkton, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Taylor M.D.
25C. FUNERAL DIRECTOR: [illegible] ADDRESS: New Freedom, Pa.

VS 150-REV. 1/1/65

L-520

BIRTH NO. 67 1684

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1684

1. NAME OF DECEASED (Type or Print): MARIAN REED LYNCH

2. DATE AND HOUR OF DEATH: 2-16-67 | 7:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO 27-01

D. STREET ADDRESS (If rural, give location): 4117 EILERMAN AVE.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-15-02

9. AGE (In years last birthday): 65

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF

10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. REED

14. MOTHER'S MAIDEN NAME: ARIN ~~UNKNOWN~~ DULY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-07-9445

17. INFORMANT: CHART

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 4201

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction

DUE TO

(B)

DUE TO

(C) MI Injury

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-11 19 67 to 2-16 19 67, that (I) (we) last saw the deceased alive on 2-16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frank A. Carozza M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-16-67

23C. PHYSICIAN'S NAME (Type): DR. FRANK A. CAROZZA M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/18/67

24C. NAME of CEMETERY or CREMATORY: MORELAND MEMORIAL

24D. LOCATION (City, town, or county): PARKVILLE (State): MD

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: ULLRICH FUNERAL HOME

ADDRESS: 4216 BELAIR.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1685 Registered No. 67 1685

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LIPSITZ - IDA

2. DATE AND HOUR OF DEATH: 2/14/67 - 7:05 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND - B. COUNTY: 22-20

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE - MD.

D. STREET ADDRESS (If rural, give location): 7014 FIELDCREST Rd.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 1890 [redacted]

9. AGE (In years last birthday): [redacted] 77

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): [redacted] RUSSIA

12. CITIZEN OF WHAT COUNTRY? USA ?

13. FATHER'S NAME: Charles Savage

14. MOTHER'S MAIDEN NAME: Anna Getz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-09-9448

17. INFORMANT: Mr. Samuel Lipsitz, 7014 Fieldcrest Road ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction

DUE TO

(B) Arteriosclerotic Cardiovascular disease

DUE TO

(C) Ca of the Rectum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/27/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of Anorectal Area

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 23 1966 to February 14 1967, that (I) (we) last saw the deceased alive on February 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Francisco D. Sabado, Jr. M.D. Attending Phys. ☐ Med. Director ☑ Staff Phys. ☐

23B. DATE SIGNED: Feb. 14, 1967

23C. PHYSICIAN'S NAME (Type): Francisco D-Sabado, Jr. M.D.

23D. ADDRESS: SINAI HOSP. OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/16/67

24C. NAME of CEMETERY or CREMATORY: Hebrew Friendship

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., 6010 Reist., Rd. ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-350

BIRTH NO. 67 1686

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1686

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WINIFRED BEETHAM

2. DATE AND HOUR PRONOUNCED DEAD: February 17, 1967 | 8:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 155 N. Ellwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-01

D. STREET ADDRESS (If rural, give location): 155 N. Ellwood Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): DIVORCED

8. DATE OF BIRTH: 4-5-14

9. AGE (In years last birthday): 52

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FREDERICK COLLINS

14. MOTHER'S MAIDEN NAME: MARY GRIFFIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MRS. GEORGE WAGNER

ADDRESS: 2911 E. BALTO. ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 581.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fatty Metamorphosis of Liver

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes PARTIAL

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker MD

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/17/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 2-18-67

23C. NAME of CEMETERY or CREMATORY: WOODLAWN CEMETERY

23D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

24B. NAME OF REGISTRAR: Robert E. Faulkner M.D.

24C. FUNERAL DIRECTOR: Nicholas T. Matthews

ADDRESS: 3021 EASTERN AVE.

#24

VS 151-REV. 1/1/65

B 0 0 1 6 8 9

K-231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1687 Registered No. 67 1687

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Kastner, Carl A.

2. DATE AND HOUR OF DEATH: Febr. 17th 1967 at 6:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Md. B. COUNTY: 21-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 1205 Carroll St. (21230)

5. SEX: M 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married 8. DATE OF BIRTH: Aug 30th 1900 9. AGE (In years last birthday): 66 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Retired~~ Guard 10B. KIND OF BUSINESS OR INDUSTRY: Western Electric 11. BIRTHPLACE (State or foreign country): Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Kastner 14. MOTHER'S MAIDEN NAME: Elizabeth Wissel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: 213-10-5318 17. INFORMANT: Helen Kastner ADDRESS: Above

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Kidney tumor, Nephrolithiasis

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Febr. 9th 1967 to Febr. 17 1967, that (I) (we) last saw the deceased alive on Febr. 16th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Vigl. Jón Jónsteinsson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: Febr. 17 67

23C. PHYSICIAN'S NAME (Type): Vigl. Thor Thorsteinsson M.D. 23D. ADDRESS: Univ. Hospital, Balto

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2/20/67 24C. NAME of CEMETERY or CREMATORY: Meadowridge Cem. 24D. LOCATION (City, town, or county) (State): Dorsey Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967 25B. NAME OF REGISTRAR: Roberta E. Jackson 25C. FUNERAL DIRECTOR: John J. Cavanaugh Son Inc. ADDRESS: Balto Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-56 B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1688 Registered No. 67 1688

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Samuel Earl Conner

2. DATE AND HOUR OF DEATH: Feb. 15, 1967 | 5:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-36

D. STREET ADDRESS (If rural, give location): 6605 Gary Avenue -21222

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12-27-1885

9. AGE (In years last birthday): 81

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Clerk

10B. KIND OF BUSINESS OR INDUSTRY: W. P. Ihrie & Sons

11. BIRTHPLACE (State or foreign country): St. Michael's Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Conner

14. MOTHER'S MAIDEN NAME: --- Jewel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-05-9495

17. INFORMANT: Mrs. Helen S. Conner ADDRESS: 6605 Gary Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 14 19 66 to 2/15 19 67, that (I) (we) last saw the deceased alive on 2/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. H. Goodman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/16/67

23C. PHYSICIAN'S NAME (Type): J. H. Goodman M.D.

23D. ADDRESS: 3400 E Baltimore St Balto Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-18-67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-600.1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1689

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EMIDIO FIORE — EMIDIO FIORE

2. DATE AND HOUR OF DEATH: Feb. 17, 1967 8:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 10-01
D. STREET ADDRESS (If rural, give location): 609 E. Biddle St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: Oct 11, 1886
9. AGE (In years lost birthday): 80
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 220-01-6025
17. INFORMANT: MRS Rose Smith
ADDRESS: 1810 Dover St

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute fatty infiltration - unknown
DUE TO
(B) of the liver
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 16 1967 to Feb. 17 1967, that (I) (we) last saw the deceased alive on 8:00 Am 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: Feb. 17, 1967
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: MERCY HOSP. INC

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Feb. 21, 1967
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [signature] M.D.
25C. FUNERAL DIRECTOR: Walters Funeral Home
ADDRESS: Pratt & Stricker Sts.

VS 150-REV. 1/1/65

1693

IW

ML 600 67-0342

BIRTH NO. 67 1690

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1690 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby boy Moore, ~~Barbara~~

2. DATE AND HOUR OF DEATH: 2/15/67 12 30/A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3 Baltimore City Hospital 4940 Eastern Ave., Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 8 49 St. Boniface Lane 21222

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, ~~DIVORCED~~ (specify): Never Married
8. DATE OF BIRTH: 2/14/67
9. AGE (In years last birthday): 6 hrs — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 6 Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Robert Moore
14. MOTHER'S MAIDEN NAME: Barbara Connors
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 — ADDRESS:

MEDICAL CERTIFICATION

1B. 762.5

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Anoxia — 6 hrs
DUE TO
(B) Respiratory distress syndrome — 6 hrs
DUE TO
(C) Prematurity — 6 hrs

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 14 1967 to Feb. 15, 1967, that (I) (we) last saw the deceased alive on Feb. 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A M Overbach M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. [X]
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): A.M. OVERBACH M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 2-16-67
24C. NAME of CEMETERY or CREMATORY: Baltimore City Hospitals
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR — ADDRESS: HOSPITAL DISPOSAL

VS 150-REV. 1/1/65

0 1 6 9 4

48-26-14
FR

15-552-67 1691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1691

BIRTH NO. 66-16049
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JENNINGS, BABY BOY, ~~Loretta~~

2. DATE AND HOUR OF DEATH: 2/6/67 | 9:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Avenue, Baltimore, Maryland 21224
31 BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-06
D. STREET ADDRESS (If rural, give location): 9 SOUTH HILTON STREET 21229

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	NEGRO	NEVER MARRIED	12-7-66		2	0		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NOT GIVEN
14. MOTHER'S MAIDEN NAME: LORETTA JENNINGS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue
ADDRESS: 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 799X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) RESPIRATORY PARALYSIS
DUE TO
(B)
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(C) VIRAL PNEUMONIA — 3 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ ~~Not~~ While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/7 1966 to 2/6 1967, that (I) (we) last saw the deceased alive on 2/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Margaret E. Lang, MD — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/6/67
23C. PHYSICIAN'S NAME (Type): MARGARET E. LANG MD — M.D.
23D. ADDRESS: 4940 Eastern Avenue, Baltimore City Hospitals, Balt. Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	2-10-67	Baltimore City Hospitals	Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1692 Registered No. 67 1692

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HELLMERS, MARGARET E.

2. DATE AND HOUR OF DEATH: 2-16-1967 7.30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 NORTH CHARLES GEN. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: BALTIMORE 21205
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Mc ELDERRY St 7-01
D. STREET ADDRESS (If rural, give location): 2909

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 2-13-1888
9. AGE (In years last birthday): 79
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): MARYLANDBALTIMORE
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN KISTER
14. MOTHER'S MAIDEN NAME: ELIZABETH MIENER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217 09 5477 D: NO
17. INFORMANT: MRS J. BRITAIN WINTER ADDRESS: NORTH CHARLES GEN. HOSP. CHART

MEDICAL CERTIFICATION

18. 134.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Bronchopneumonia, bilat — 3 days
DUE TO
(B) Histoplasmosis
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-15 1967 to 2-16 1967, that (I) (we) last saw the deceased alive on 2-16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dr. Juan F. Aleman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-16-1967
23C. PHYSICIAN'S NAME (Type): MELITO TORRES M.D.
23D. ADDRESS: 441 S. ELLWOOD AVE. BALTIMORE 24

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: OAK LAWN CEMETERY
24D. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC. ADDRESS: BALTIMORE MARYLAND 21213

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1693 Registered No. 67 1693

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ETTA OBRECHT SHANKS

2. DATE AND HOUR OF DEATH: FEBUARY 15,1967 | 8:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 4 East 32nd Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-02

D. STREET ADDRESS (If rural, give location): 4 EAST ~~xx~~ 32nd Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widow	Feb. 27,1899	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Marker	Dept Store Retired	Baltimore, Maryland	USA

13. FATHER'S NAME: Charles F. Obrecht

14. MOTHER'S MAIDEN NAME: Josephine Schlemmer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	212	22 7751	Mr. Charles F. Obrecht	Munsey Building

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Arteriosclerotic cardio-vascular disease	10 yrs.
(B) DUE TO	Emphysema	5 yrs.
(C)	Rheumatoid arthritis	10 yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan. 31 19 67 to Feb. 15, 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 9, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. [X] Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/17/67

23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.

23D. ADDRESS: 3902 Greenmount Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/18/67	Loudon Park Cemetery	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 20 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC.

ADDRESS: BALTIMORE MARYLAND 21213

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-623

BIRTH NO. 67 1691

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1691

1. NAME OF DECEASED (Type or Print): MARGARET GRIEST

2. DATE AND HOUR OF DEATH: 2/16/67 | 1:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Md GEN HOSP BALTO. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: Harford Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): DARLINGTON 21034 62-00

D. STREET ADDRESS (If rural, give location): BOX 115

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NOT MARRIED

8. DATE OF BIRTH: 11/30/18

9. AGE (In years last birthday): 48

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Griest

14. MOTHER'S MAIDEN NAME: Nellie Wahnes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

16. (If yes, give war or dates of service)

SOCIAL SECURITY NO.:

17. INFORMANT: Kenneth R Koskinen MD

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/23 1967 to 2/16 1967. that (I) (we) last saw the deceased alive on 2/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R Koskinen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/16/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: Md Gen Hosp Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/19/67

24C. NAME of CEMETERY or ~~CREMATORY~~: DARLINGTON CEMETARY

24D. LOCATION (City, town, or county) (State): DARLINGTON, MD

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney M.D.

25C. FUNERAL DIRECTOR: Ralph M. Reed

ADDRESS: Rising Sun Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-425

67-02935 67 1695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 2/229 67 1695

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROSLYN NELSON

2. DATE AND HOUR OF DEATH: Feb. 16th 1967 | 5:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-04

D. STREET ADDRESS (If rural, give location): 4219 Floweston Rd.

5. SEX: F.

6. RACE: C.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 2-14-67

9. AGE (In years last birthday):

If Under 1 Yr. Months: Days: 3 | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Randolph Nelson

14. MOTHER'S MAIDEN NAME: Lillian Tucker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Randolph, father

ADDRESS: same

MEDICAL CERTIFICATION

1B. 560.2

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory Arrest — 2 days.

DUE TO

(B) Omphalocele Repaired — 3 days

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/14/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 14 1967 to Feb. 16 1967, that (I) (we) last saw the deceased alive on Feb 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Wonja Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/16/67

23C. PHYSICIAN'S NAME (Type): WONJA KIM M.D.

23D. ADDRESS: Lutheran Hosp. of MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Balto. Int. Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: Earl Holmore

ADDRESS: 1827 W. North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

F-630

67 1696

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1696

1. NAME OF DECEASED (Type or Print): Annie Ford

2. DATE AND HOUR PRONOUNCED DEAD: 2/19/67 | 3:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06

D. STREET ADDRESS (If rural, give location): 2738 Baker St.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Oct. 31, 1898

9. AGE (In years last birthday): 68

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicholas Bode

14. MOTHER'S MAIDEN NAME: Lena Feisler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-20-9584

17. INFORMANT: Mr. Herbert C. Ford, ADDRESS: Same as # 4

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/19/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Feb. 22, 1967

23C. NAME of CEMETERY or CREMATORY: Poplar Grove Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

24B. NAME OF REGISTRAR: Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, ADDRESS: 1050 York Road Towson, Md. 21204

VS 151-REV. 1/1/65

H-353

BIRTH NO. 67 1697

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1697

1. NAME OF DECEASED (Type or Print): HODNETT, GEORGE WASHINGTON

2. DATE AND HOUR OF DEATH: 2/20/67 1:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-05

D. STREET ADDRESS (If rural, give location): 633 GORSUCH AVE

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 07-3-88

9. AGE (In years last birthday): 78

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S

13. FATHER'S NAME: BENJAMIN HODNETT

14. MOTHER'S MAIDEN NAME: LUCY WOOD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-10-1936

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 156.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) METASTATIC CANCER

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: LIVER BIOPSY

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CANCER OF THE LIVER

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 01-20-67 19 to 02-20 19 67, that (I) (we) last saw the deceased alive on 02-19- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 02-20/67

23C. PHYSICIAN'S NAME (Type): ZOLTAN ZARDAY, M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: Meadowridge

24D. LOCATION (City, town, or county) (State): Anna Arundle County

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc.

ADDRESS: Baltimore, Md. 21202

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-62

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1698 Registered No. 67 1698

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph F. HARRIGAN

2. DATE AND HOUR OF DEATH: 2/19/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 817 N. Charles

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	11/11/94	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintenance	Medical Arts Bldg	Baltimore	USA

13. FATHER'S NAME: Timothy Harrigan

14. MOTHER'S MAIDEN NAME: Ellen Doory

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-09-4042

17. INFORMANT: Mrs Lillian Harrigan ADDRESS: Balt. Md. 817 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: ASCVD, possible myocardial infarction, congestive heart failure

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 18 1967 to Feb 19 1967, that (I) (we) last saw the deceased alive on Feb 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis E. Grenzer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/19/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc. ADDRESS: Baltimore, Md. 21202

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2/27/67 - Pneumococcal meningitis -
Information from Bur. of Comm. Dis.
Ballo. City H. Dept.

K-50

BIRTH NO. 67 1699

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1699

1. NAME OF DECEASED (Type or Print): KENNEY, VALLIE

2. DATE AND HOUR OF DEATH: 2/19/67 3:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 10-05

D. STREET ADDRESS (If rural, give location): 1713 N, CALVERT STREET

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWER

8. DATE OF BIRTH: 8-8-03

9. AGE (In years last birthday): 63

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: COLUMBUS UTTERBACK

14. MOTHER'S MAIDEN NAME: MATTIE JENKINS.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Mrs Ward Utterback

ADDRESS: 3034 Abell Ave Balt. Md.

MEDICAL CERTIFICATION

18. I — CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: ≈ 15 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-26 19 67 to 2/19 19 67, that (I) (we) last saw the deceased alive on 2/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sherrard Hayes M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/19/67

23C. PHYSICIAN'S NAME (Type): DR. SHERRARD HAYES. M.D.

23D. ADDRESS: JHH

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National

24D. LOCATION (City, town, or county) (State): Catonsville, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Faber

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc.

ADDRESS: Baltimore, Md. 21202

VS 150-REV. 1/1965

703

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

40-59-24 TB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1700

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1700

1. NAME OF DECEASED (Type or Print): MRS ISABEL HILLEARY

2. DATE AND HOUR OF DEATH: 2-19-67 1 45 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

12-02

D. STREET ADDRESS (If rural, give location): 3111 N. CHARLES ST., APT 3C-#21218

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 9-4-74

9. AGE (In years last birthday): 92

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EDWARD S.

14. MOTHER'S MAIDEN NAME: ISABEL GAVET

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE

ADDRESS: #21224

MEDICAL CERTIFICATION

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) GANGRENE R leg

DUE TO

(B) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO

(C) CORONARY ARTERY DISEASE

INTERVAL BETWEEN ONSET AND DEATH: 3 WK.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CEREBRAL VASCULAR DISEASE 3 YR.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-9 1967 to 2-19 1967, that (I) (we) last saw the deceased alive on 2-19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. C. Cameron M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-19-67

23C. PHYSICIAN'S NAME (Type): E. C. CAMERON M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Balto. City, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Starbuck

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.

ADDRESS: 1217 St Paul St.

VS 150-REV. 1/1/65

48-73-02 ED 15-552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1701 Registered No. 67 1701

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Simms, Helen G.

2. DATE AND HOUR OF DEATH: 2/18/67 9:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto City Hosp. 4940 Eastern Ave. Baltimore, Maryland # 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 53-00

D. STREET ADDRESS (If rural, give location): 7902 Bridge Ave.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widow

8. DATE OF BIRTH: 3-2-87

9. AGE (In years last birthday): 79

If Under 1 Y.: Months Days

If Under 24 Hrs.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Manning

14. MOTHER'S MAIDEN NAME: Margaret Fitzpatrick

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md. # 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

(B) Pleural effusion Cataleptaris

DUE TO

(C) Metastases from Ca, breast

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2 1963

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca breast

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 2/18 1967 to 2/18 1967, that (I) (we) last saw the deceased alive on 2/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. T. Davids M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/18/67

23C. PHYSICIAN'S NAME (Type): J. T. Davidson M.D.

23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: Most Holy Redeemer

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Lankenau

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc.

ADDRESS: Baltimore, Md. 21202

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1702 Registered No. 67 1702

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PARKER, EMMA MAE

2. DATE AND HOUR OF DEATH: 2-18-67 | 11:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dulaland Nursing Home 90 1501 Dulaland St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-03

D. STREET ADDRESS (If rural, give location): 4514 Fair Fax Rd.

5. SEX: Fe

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 7-28-1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Bunker Hill W. VA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bradford Williams

14. MOTHER'S MAIDEN NAME: Lucy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 233-50-9343A

17. INFORMANT: Dulaland Nursing Home ADDRESS: 1501 Dulaland Street

MEDICAL CERTIFICATION

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic Hrt Disease

DUE TO

(B) Congestive Hrt Failure 1 wk.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-27- 1967 to 2-18- 1967, that (I) (we) last saw the deceased alive on 2-17- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Percival C. Smith M.D. Attending Phys. ☐ Med. Director ☑ Staff Phys. ☐

23B. DATE SIGNED: 2-20-67

23C. PHYSICIAN'S NAME (Type): Dr. Percival C. Smith M.D.

23D. ADDRESS: 1709 Gwynns Falls Parkway

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): MARTINSBURG W. VA

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Thomas P. Hagan ADDRESS: 1354 Gilmor

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-452

67 1703

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1703

1. NAME OF DECEASED (Type or Print): Cora Mullinix

2. DATE AND HOUR PRONOUNCED DEAD: 2/18/67 | 12:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Howard Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lisbon 63-00

D. STREET ADDRESS (If rural, give location):

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: June 12, 1891

9. AGE (In years last birthday): 75 Yrs

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jerome Grimes, Jr.

14. MOTHER'S MAIDEN NAME: Elizabeth Meade Molesworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Jerome J. Mullinix, R#2 Finksburg, Md

ADDRESS:

MEDICAL CERTIFICATION

1B. E970.8

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Overdose of Darvon Compound

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Lisbon, Maryland 63-00

21D. TIME OF INJURY (APPROX.): (Month) 2 (Day) 17 (Year) '67 (Hour) 5:30 PM

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Ingested overdose of Darvon

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: 2/18/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/20/67

23C. NAME of CEMETERY or CREMATORY: Howard Chapel Meth.

23D. LOCATION (City, town, or county) (State): Long Corner, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

24B. NAME OF REGISTRAR: Robert E. Farley

24C. FUNERAL DIRECTOR: Olin L. Molesworth, Damascus, Md.

ADDRESS:

VS 151-REV. 1/1/65

N974.0

W-426

BIRTH NO. 67-03688 67 1701

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 17014

1. NAME OF DECEASED (Type or Print): BABY GIRL WELCHER

2. DATE AND HOUR OF DEATH: 2-17-67 11.00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

CERTIFICATE AMENDED 3-8-67

A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-11

D. STREET ADDRESS (If rural, give location): 3912 WABASH AVENUE 21215

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED

8. DATE OF BIRTH: 2-17-67

9. AGE (In years last birthday): --

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 8 Min.: 25

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Frederick Welcher ~~SAMUEL WASHINGTON~~

14. MOTHER'S MAIDEN NAME: ~~HENRIETTA SCOTT~~ Doris

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT:

ADDRESS:

MEDICAL CERTIFICATION

18. 726X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Prematurity

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 9 hrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/17 1967 to 2/17 1967, that (I) (we) last saw the deceased alive on 2/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth L. Berns M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/17/67

23C. PHYSICIAN'S NAME (Type): KENNETH L. BERNS M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION REMOVAL (Specify): CREMATION

24B. DATE: 2-17-67

24C. NAME of CEMETERY or CREMATORY: The Johns Hopkins Hospital

24D. LOCATION (City, town, or county) (State): 601 N. Broadway Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from M.H.H 3-8-67 M.H.

1

N-520

BIRTH NO. 67 1705

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1705

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Harold Nance

2. DATE AND HOUR PRONOUNCED DEAD: 2/18/67 10:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-01

D. STREET ADDRESS (If rural, give location): 2026 Eastern Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: March 5, 1930

9. AGE (In years last birthday): 36

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nance

14. MOTHER'S MAIDEN NAME: Georgia Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Georgia Nance, Appalachia, Va.

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. E981X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Transection of aorta with massive

DUE TO internal bleeding

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Gunshot wound of left buttock

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): woods

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): rear of 4927 Leeds Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2 18 67 10:10p.m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? shot in buttock

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/19/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/23/67

23C. NAME of CEMETERY or CREMATORY: Riverview Cemetery

23D. LOCATION (City, town, or county) (State): Big Stone Gap, Virginia

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

24B. NAME OF REGISTRAR: Robert E. Fashena

24C. FUNERAL DIRECTOR: Ullrich Funeral Home

ADDRESS: 4210 Belair Road.

VS 151-REV. 1/1/65

N879.4767 0001709

C-514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1706 Registered No. 67 1706

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Wm. T. Campbell

2. DATE AND HOUR OF DEATH: 18 Feb 67 | 10 25a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Fayette Convalescent Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balt
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt 7-02
D. STREET ADDRESS (If rural, give location): 2425 E Madison St 21205

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Wid
8. DATE OF BIRTH: 18 Oct 93
9. AGE (In years last birthday): 73
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Guard
10B. KIND OF BUSINESS OR INDUSTRY: City of Balto.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 228 14 1880 A
17. INFORMANT: Doris Simons 1411 Alexis Dr Joppa Md ADDRESS

MEDICAL CERTIFICATION

18. 491 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Bronchopneumonia — 1 wk

(B) DUE TO:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. rheumatoid, emphysema, anemia, peptic ulcer, hiatal HASCVD

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10 Feb 1967 to 18 Feb 1967, that (I) (we) last saw the deceased alive on 18 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J Hulla M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 18 Feb 67
23C. PHYSICIAN'S NAME (Type): J. Hulla M.D.
23D. ADDRESS: 2214 E Fayette St 21231 Balt Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67 XXXXXXXXXX
24C. NAME OF CEMETERY OR CREMATORY: Fairfiled Baptist Church
24D. LOCATION (City, town, or county): Burgess (State): Virginia

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave ADDRESS

VS 150-REV. 1/1/65

6 7 0 0 0 1 7 1 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460

BIRTH NO. 67 1707

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1707

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): E. Estella Miller.

2. DATE AND HOUR OF DEATH: 2/16/67 | 3⁵⁵ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balt. City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt. City
D. STREET ADDRESS (If rural, give location): 3607 Lochearn Drive Balt 21207

42 53-00

5. SEX: F
6. RACE: Caue
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: Oct 28/90
9. AGE (In years last birthday): 76
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Gith
14. MOTHER'S MAIDEN NAME: Anna Cole

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 230-30-6059
17. INFORMANT: Mr. Ralph W. Miller 3503 Lochearn Drive ADDRESS Balto 21207

MEDICAL CERTIFICATION

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH
(A) Pulmonary Embolism — 2 hours
DUE TO
(B) post fx of hip and reduction — 48 hrs.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY ASST. MEDICAL EXAMINER 2/19/67

E903.0

19A. DATE OF OPERATION: 2/14/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: fx of hip
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Balt. City (home)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2 14 67
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒
21F. HOW DID INJURY OCCUR? Slipped

22. I certify that (I) (this hospital) attended the deceased from 2/14/67 19 to 2/16/67 19, that (I) (we) last saw the deceased alive on 2/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. (No autopsy)

23A. SIGNATURE: B. Lindenbaum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/16/67
23C. PHYSICIAN'S NAME (Type): B. LINDENBAUM M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: Lorraine Cemetery
24D. LOCATION (City, town, or county) (State): Balto 7 Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Foley M.D.
25C. FUNERAL DIRECTOR: Irving Byers ADDRESS 8728 Liberty Road

VS 150-REV. 1/1/65

A-352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1708 Registered No. 67 1708

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Harry Adams

2. DATE AND HOUR OF DEATH: 2-18-67 2 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13 26-03
D. STREET ADDRESS (If rural, give location): 3720 Elmora Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 12-24-19
9. AGE (In years last birthday): 47
If Under 1 Yr. Months Days Hours; If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Disabled
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John P Adams
14. MOTHER'S MAIDEN NAME: Mary Leary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 230-12-8696
17. INFORMANT: Martha Adams 3720 Elmora Avenue 13 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA
DUE TO
(B) CHRONIC NEFRITIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ —
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from February 14 1967 to February 17 1967, that (I) (we) last saw the deceased alive on February 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S Brahim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/17/67
23C. PHYSICIAN'S NAME (Type): BRAHIM, SAMI M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-21-1967
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Tokayer
25C. FUNERAL DIRECTOR: Lagoda Funeral Home 740 Belair Rd ADDRESS 36

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-621

BIRTH NO. 67 1709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1709

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH ANN MARSHALL

2. DATE AND HOUR OF DEATH: FEB. 12, 1967 2:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 831 N. GILMORE ST. BALTIMORE, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16-02

D. STREET ADDRESS (If rural, give location): 831 N. GILMORE ST.

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 6/11/99

9. AGE (In years last birthday): 67

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEACHER

10B. KIND OF BUSINESS OR INDUSTRY: County Schools

11. BIRTHPLACE (State or foreign country): BALTIMORE, M.D.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. THOMAS

14. MOTHER'S MAIDEN NAME: JENNIE FLEET

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-36-9013-A

17. INFORMANT: GERTRUDE JONES ADDRESS: (same)

MEDICAL CERTIFICATION

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARCINOMA OF BREAST

DUE TO

WITH METASTASES

(B) DUE TO TO RIB, SKULL + BRAIN — 3-4 months

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION: 1/23/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca, breast

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from 1963 19 to 2/12 1967, that (I) (~~we~~) last saw the deceased alive on 2/12 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: D. Stewart, M.D. M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/12/67

23C. PHYSICIAN'S NAME (Type): D. W. STEWART, M.D. M.D.

23D. ADDRESS: 3414 Duvall Av. Balto., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/16/67

24C. NAME of CEMETERY or CREMATORY: Arlington Memorial Pk.

24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Fackenthal

25C. FUNERAL DIRECTOR: Hayleigh E. Sutton

ADDRESS: 3035 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

T-460

BIRTH NO. 67 1710

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1710

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD: February 16, 1967 4:20 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-06

D. STREET ADDRESS (If rural, give location): 2925 Mosher Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Widowed	Oct. 4, 1870	95		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	Construction Co.	Howard Co. Md	U.S.A.

13. FATHER'S NAME: Washington Taylor

14. MOTHER'S MAIDEN NAME: Mariale Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-09-1754

17. INFORMANT: Mrs Agnes Welch ADDRESS: 2925 Mosher St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 4221

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/16/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/20/67	Western Star Cem	Baltimore Co. Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 21 1967		Herbert E. Nutter	3035 W. North Ave

VS 151-REV. 1/1/65

0 1 7 1 4

S-16

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1711 Registered No. 67 1711

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Spruell George

2. DATE AND HOUR OF DEATH 2.16.67 3:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-10

D. STREET ADDRESS (If rural, give location) 4117 PENHURST AVE

42

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed 8. DATE OF BIRTH 5.1.08 9. AGE (In years last birthday) 58 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer 10B. KIND OF BUSINESS OR INDUSTRY Officer's Mess 11. BIRTHPLACE (State or foreign country) Norfolk, Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lonnie Spruell 14. MOTHER'S MAIDEN NAME Eleanor Fleece

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Miss Dorothy Spruell ADDRESS 540 McMechen St

MEDICAL CERTIFICATION

I

1B. 5420

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Gastro-Duodenal ulcer

DUE TO

(B) Massive Hemorrhage

DUE TO

(C) Post. op Gastrectomy

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2.10.67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Massive GI. Bleeding 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2.16 1967 to 2.16 1967. that (I) (we) last saw the deceased alive on 2.16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE R. Theodore M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type) ROGER THEODORE M.D. 23D. ADDRESS Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/21/67 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park 24D. LOCATION (City, town, or county) Baltimore County (State) Md

25A. DATE REC'D BY HEALTH DEPT. FEB 21 1967 25B. NAME OF REGISTRAR Robert E. Faber M.D. 25C. FUNERAL DIRECTOR Herbert E. Nutter ADDRESS 3035 W. North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

J-520

67 1712

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1712

1. NAME OF DECEASED (Type or Print): Annie E. Jones

2. DATE AND HOUR PRONOUNCED DEAD: 2/13/67 2:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 340 Bloom St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03

D. STREET ADDRESS (If rural, give location): 340 Bloom St.

5. SEX: female

6. RACE: colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: July 14, 1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Lancaster County, Va

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Ellicott

14. MOTHER'S MAIDEN NAME: Mary E. ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Roy Jones ADDRESS: 340 Bloom Street

MEDICAL CERTIFICATION

18. 170X

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/14/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/17/67

23C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

23D. LOCATION (City, town, or county) (State): Arbutus Balto Co. Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

24B. NAME OF REGISTRAR: Robert E. Faulkner

24C. FUNERAL DIRECTOR: Herbert E. Nutter ADDRESS: 3035 W. North AVE

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 7 1 6

S-352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1713 Registered No. 67 1713

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STANSBURY, ALEXANDER

2. DATE AND HOUR OF DEATH: 2-15-67 | 10:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALT.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 14-03

D. STREET ADDRESS (If rural, give location): 1355 N. FREMONT. FREMONT AVE

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: July 23, 1895

9. AGE (In years last birthday): 71

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY: Maryland Drydock

11. BIRTHPLACE (State or foreign country): MARYLAND (BALTIMORE)

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William STANSBURY

14. MOTHER'S MAIDEN NAME: MARY ???

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-07-3522

17. INFORMANT: AMELIA STANSBURY

ADDRESS: AS ABOVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 204.3 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE LEUKEMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS

DUE TO

(B) PNEUMONIA — 1 WK.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): ?

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-15 1967 to 2-15 1967, that (I) (we) last saw the deceased alive on 2-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael R. Siegal M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ INTERN

23B. DATE SIGNED: 2-15-67

23C. PHYSICIAN'S NAME (Type): MICHAEL R. SIEGAL M.D.

23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: BALTIMORE NATIONAL CEM.

24D. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: HERBERT E. NUTTER

ADDRESS: 3035 W. NORTH AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

67 1713

T-652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1714 Registered No. 67 1714

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANK K. TRAWINSKI

2. DATE AND HOUR OF DEATH: Feb. 18, 1967 10:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Hood Conv. Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-01 D. STREET ADDRESS (If rural, give location): 221 N. Linwood Ave.

5. SEX: M 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed 8. DATE OF BIRTH: 5-15-1878 9. AGE (In years last birthday): 88 If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Poland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: — — — — — — — — 14. MOTHER'S MAIDEN NAME: — — — — — — — — —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 21505-1189

17. INFORMANT: FRANK T. TRAWINSKI ADDRESS: 1826 HANFORD Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovasc. accident hemorrhage

DUE TO

(B) Generalized arteriosl

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1967 to Feb 18 1967, that (I) (we) last saw the deceased alive on Feb 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Kudirka M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 2.20.67

23C. PHYSICIAN'S NAME (Type): J. KUDIRKA M.D. 23D. ADDRESS: 2151 Wilken

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL 24B. DATE: 2/22/67 24C. NAME of CEMETERY or CREMATORY: Holy Rosary Cem. 24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967 25B. NAME OF REGISTRAR: [illegible] 25C. FUNERAL DIRECTOR: B. Dabrowski ADDRESS: 2518 E. Balto. St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

H-252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1715 Registered No. 67 1715

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Hawkins, Carrie S.

2. DATE AND HOUR OF DEATH: 2/18/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: St. Marys Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township): St. Inigoes 68-00 D. STREET ADDRESS (If rural, give location):

5. SEX: F

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 11-05-04

9. AGE (In years last birthday): 62 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? ?

14. MOTHER'S MAIDEN NAME: ? ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-16-6354

17. INFORMANT: John T. Hawkins ADDRESS: St Inigoes Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 792X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Verify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/26 1967 to 2/18 1967, that (I) (we) last saw the deceased alive on 2/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W S Wilson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/18/67

23C. PHYSICIAN'S NAME (Type): W Stan Wilson M.D.

23D. ADDRESS: JHH.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. 21, 1967

24C. NAME of CEMETERY or CREMATORY: Mt. Zion

24D. LOCATION (City, town, or county) (State): St. Inigoes, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner M.D.

25C. FUNERAL DIRECTOR: W. Clarke Mattingley ADDRESS: Leonardtown, Maryland

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-109

BIRTH NO. 67 1716

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1716

1. NAME OF DECEASED (Type or Print): LEVY, ANTON J

2. DATE AND HOUR OF DEATH: FEBRUARY 14, 1967 | 5:50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

ST. AGNES HOSPITAL
CATON AND WILKENS AVENUES
BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21225 A.A.Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 52.00

D. STREET ADDRESS (If rural, give location): 5215 SIXTH STREET

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 4-2-79

9. AGE (In years last birthday): 87

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: COAST GUARD YARD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: UNKNOWN DEC'D

14. MOTHER'S MAIDEN NAME: UNKNOWN DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-26-0857

17. INFORMANT: HOSPITAL SLIP-ST.AGNES HOSPITAL ADDRESS: CATON & WILKENS AVES #29

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4221

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Congestive Heart Failure
DUE TO Gangrenous left toe
(B) Arteriosclerotic cardiovascular disease
DUE TO Lobar Pneumonia
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that X (I) (this hospital) attended the deceased from 4:50P 2-14- 19 67 to 5:50P 2-14- 19 67, that X (we) last saw the deceased alive on FEBRUARY 14, 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pablo E. Dibos M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-14-1967

23C. PHYSICIAN'S NAME (Type): PABLO E DIBOS M.D.

23D. ADDRESS: ST. AGNES HOSP. CATON & WILKENS #29

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-18-1967

24C. NAME of CEMETERY or CREMATORY: Holy Cross Cemetery

24D. LOCATION (City, town, or county) (State): Ritchie Hgwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR: George J. Gonce

ADDRESS: 4001 Ritchie Hgwy., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-550

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1717

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1717

1. NAME OF DECEASED (Type or Print): MARGARET MARY NEENAN

2. DATE AND HOUR OF DEATH: FEB. 18, 1967 | 1:35 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 24-01

D. STREET ADDRESS (If rural, give location): 1642 FORT AVE

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: SEPTEMBER 11, 1904

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY: (–)

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES NEENAN

14. MOTHER'S MAIDEN NAME: MARY SLATTERY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): (–)

16. SOCIAL SECURITY NO.: (–)

17. INFORMANT: CHART

ADDRESS:

MEDICAL CERTIFICATION

1B. 416X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) cerebral anoxia

DUE TO

(B) congestive heart failure

DUE TO

(C) rheumatic heart disease

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from FEB. 1 1967 to FEB 18 1967, that ~~(I)~~ (we) last saw the deceased alive on FEB 18 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Ferdinand C. Rodriguez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/18/67

23C. PHYSICIAN'S NAME (Type): FERDINAND C. RODRIGUEZ M.D.

23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): B

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Holy Cross

24D. LOCATION (City, town, or county) (State): Balto.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Roland E. Boyd

25C. FUNERAL DIRECTOR: H. Gray

ADDRESS: 130 E Fort Ave

VS 150-REV. 1/1/65

C-200

BIRTH NO. 67 1718

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1718

1. NAME OF DECEASED (Type or Print): Maude Cox

2. DATE AND HOUR OF DEATH: February 17, 1967 10:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTIMORE GENERAL HOSPITAL 1213 Light Street Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1524 Riverside Avenue

24-04

43

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 12/15/75
9. AGE (In years last birthday): 91
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Whitehouse
14. MOTHER'S MAIDEN NAME: Ellen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

I

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — 19 days

DUE TO

(B) Atherosclerotic Cardiovascular Dis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from January 29, 1967 to February 17, 1967, that (X) (we) last saw the deceased alive on February 17, 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Albert T. Miller M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: February 18, 1967

23C. PHYSICIAN'S NAME (Type): Albert T. Miller M.D.
23D. ADDRESS: SOUTH BALTIMORE GENERAL HOSPITAL 1213 Light Street Balto., Md. 21230

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 2-21-67
24C. NAME of CEMETERY or CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: McCarey
ADDRESS: 130 E Fort Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1967 00 1718

P-625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1719 Registered No. 67 1719

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LORETTA V. PERKINS

2. DATE AND HOUR OF DEATH: 2-19-67 | 2 08 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 S. Balto. Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23-02

D. STREET ADDRESS (If rural, give location): 1102 Marshall St. #30

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Seperated

8. DATE OF BIRTH: 1-10-1915

9. AGE (In years last birthday): 52

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: LARENCE Boyd

14. MOTHER'S MAIDEN NAME: Alice (UKN.)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: John Perkins ADDRESS: Hilltop Lane Ellicott City, Md.

MEDICAL CERTIFICATION

18. 162.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) BILATERAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS

DUE TO

(B) BILATERAL BRONCHOGENIC CARCINOMA — SEVERAL MONTHS TO YEARS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-10-1967 to 2-19-1967, that (I) (~~we~~) last saw the deceased alive on 2 P.M. 2-19-1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Harold A. Burnham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-19-67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-22-67

24C. NAME of CEMETERY or CREMATORY: Glen Haven Cemetery

24D. LOCATION (City, town, or county) (State): Glen Burnie Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. [illegible]

25C. FUNERAL DIRECTOR: McGuire 130 E. Fort Ave. ADDRESS: Balto #30 Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-4161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1720 Registered No. 67 1720

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EVA FAMOUS GALBREATH

2. DATE AND HOUR OF DEATH: 2-17-67 8⁴⁰ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Harford Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Street 62-00
D. STREET ADDRESS (If rural, give location): Box 549

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	12-05-02	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: JOHN FAMOUS

14. MOTHER'S MAIDEN NAME: LOUANNA RIGDON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 117-32-5722

17. INFORMANT: Patient Chart ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Multiple thrombosis (TROUSSEAU)
DUE TO
(B) Carcinoma of pancreas with metastases
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-4 19 67 to 2-17 19 67, that ~~(I)~~ (we) last saw the deceased alive on 2-16 19 67 and that In ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (did ~~not~~) view the body after death.

23A. SIGNATURE: John R. Vaughn Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/17/67

23C. PHYSICIAN'S NAME (Type): JOHN R. VAUGH, JR. M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-20-67

24C. NAME of CEMETERY or CREMATORY: HIGHLAND

24D. LOCATION (City, town, or county) (State): STREET, HARFORD CO., MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Fogle, M.D.

25C. FUNERAL DIRECTOR: John H. Harkins ADDRESS: DELTA, PA.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1721 Registered No. 67 1721

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Samuel Harrison

2. DATE AND HOUR OF DEATH: 2-19-67 | 5:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 14-02

D. STREET ADDRESS (If rural, give location): 548 Wilson Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12-20-1905

9. AGE (In years): 61 yrs.

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: S. Harrison

14. MOTHER'S MAIDEN NAME: Eliza Forturne

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217036686

17. INFORMANT: Mrs. Ollie Holden - daughter ADDRESS: 1359 North Stockton St.

MEDICAL CERTIFICATION

1B. 570.2

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia, Hypostatic — 6 days

DUE TO

(B) Intestinal Obstruction - Gangrene of Ileum — 12 days

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart Failure

19A. DATE OF OPERATION: 2-13-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 29, 1967 to February 19, 1967, that (I) (we) last saw the deceased alive on February 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rosario A. Bello M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-20-67

23C. PHYSICIAN'S NAME (Type): Rosario Bello, M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-22-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pkark

24D. LOCATION (City, town, or county) (State): Arbutus Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 N. Calhoun

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-600

67 1722

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 1722

BIRTH NO.

M.E. CASE NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MINERVA BERRY

2. DATE AND HOUR PRONOUNCED DEAD: February 11, 1967 9:38 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 538 Moore Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01

D. STREET ADDRESS (If rural, give location): 538 Moore Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: June 13-1896

9. AGE (In years last birthday): 70

If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alvin Berry ADDRESS: 1381 Whatcoat St

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 422.2

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brown Atrophy of Heart.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/11/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2-21-67

23C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.

23D. LOCATION (City, town, or county): A.A. Co. (State): Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Morton & Dyett F.H.

ADDRESS: 1701 Laurens

VS 151-REV. 1/1/65

6-450

BIRTH NO. 67 1723

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1723

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Gilliam, Samuel NMI

2. DATE AND HOUR OF DEATH: February 19, 1967 | 7:30Am.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, maryland 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Alexandria
V-43
D. STREET ADDRESS (If rural, give location): 515 North Patrick Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 3/8/25
9. AGE (In years last birthday): 41
If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Ceasar Gilliam
14. MOTHER'S MAIDEN NAME: Lucy Fields

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 8/11/43-6/18/46
16. SOCIAL SECURITY NO.: 229-18-59-29
17. INFORMANT: Veterans Hospital Records, Balto., Md.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

162.1

(A) DUE TO: Metastatic epidermoid carcinoma of liver. Primary site unknown lung suspected — 2 months
(B) DUE TO:
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 1, 1967 to February 19, 1967, that (I) (we) last saw the deceased alive on February 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Barry N. Rosenbaum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/20/67
23C. PHYSICIAN'S NAME (Type): BARRY N. ROSENBAUM M.D.
23D. ADDRESS: Veterans Hospital, balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-23-67
24C. NAME of CEMETERY or CREMATORY: Alexander Nat. Cem.
24D. LOCATION (City, town, or county) (State): Alexander Va.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Tankey M.D.
25C. FUNERAL DIRECTOR: Arnold Funeral Home
ADDRESS: Alexandria Va.

VS 150-REV. 1/1/65

48-71-13 TN

FR 400 67 1724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1724

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Royal, Hortense

2. DATE AND HOUR OF DEATH: 2/21/67 5:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 900 N. Gilmor Street 21217

16-03

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED

8. DATE OF BIRTH: 10-19-26

9. AGE (In years last birthday): 40

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES HAWKINS

14. MOTHER'S MAIDEN NAME: CARRIE BROWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: BCH: RECORDS

ADDRESS: 4940 EASTERN AVENUE 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Cardiac arrest

(B) DUE TO: Gram negative sepsis

(C) Pneumonia and/or bacterial peritonitis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic alcoholism

19A. DATE OF OPERATION: 2/16/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Empyema of gall bladder

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2/16/67 19__ to 2/21/67 19__, that ~~(I)~~ (we) last saw the deceased alive on 2/21/67 19__ and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Carl Winterstein M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): DR. CARL WINTERSTEIN M.D.

23D. ADDRESS: Balto. City. Hospitals 4940 Eastern Ave Balto, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-24-67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Cheryl Wilson

ADDRESS: 1011 Brunetty St.

VS 150-REV. 1/1/65

G-40

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1725 Registered No. 67 1725

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John Joseph Gola — John Joseph Gola

2. DATE AND HOUR OF DEATH: February 20, 1967 | 4:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6
D. STREET ADDRESS (If rural, give location): 3813 Biddison Lane

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	June 24, 1902	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Retail Bakery	Poland	USA

13. FATHER'S NAME: Joseph Gola

14. MOTHER'S MAIDEN NAME: Roselie Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: 217-76-6697

17. INFORMANT: Mrs. Ida Gola, Mrs. Ida Gola (wife) — ADDRESS: 3813 Biddison Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
4221	(A) Bronchopneumonia	3-4 days
	DUE TO (B) Congestive heart failure	? days
	DUE TO (C) ASCVD	8-? yrs.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 19 1967 to February 20 1967, that (I) (we) last saw the deceased alive on February 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: James W. Carty Jr. M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): JAMES W. CARTY, JR., M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL — Union Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town or county) (State)
Burial	2/23/67	St. Stanislaus	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: M.F. SADOWSKI & SONS, 1808 EASTERN AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

over

VS 150-REV. 1/1/65

Hospital Letter, dated 7/26/92 - 7/30/92 —

1
W-452

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1726 Registered No. 67 1726

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Collick Myrtle A Williams

2. DATE AND HOUR PRONOUNCED DEAD: 2/18/67 | 6:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 482 Manse Ct.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 482 Manse Ct.

5. SEX: female
6. RACE: colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-15-12
9. AGE (In years last birthday): 54
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAID
10B. KIND OF BUSINESS OR INDUSTRY: DENTIST
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: SAMUEL WINDER
14. MOTHER'S MAIDEN NAME: CARRIE Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

1B. E883.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ingestion of alkaline corosive

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 482 Manse Ct. 11-04

21D. TIME OF INJURY (APPROX.) (Month) 2 (Day) 17 (Year) 67 (Hour) ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ingested alkaline corosive (probably lye)

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 2/19/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 2/22/67
23C. NAME of CEMETERY or CREMATORY: Mt. Calvary
23D. LOCATION (City, town, or county) (State): A. A. County, Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
24B. NAME OF REGISTRAR: Robert E. Foulkrod
24C. FUNERAL DIRECTOR: Joseph G. Rocks Jr
ADDRESS: 1304 N. Central Ave

VS 151-REV. 1/1/65

N964.0

G-650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1727 Registered No. 67 1727

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lottie L. Graham

2. DATE AND HOUR OF DEATH: Feb. 19, 1967 | 6:00 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1400 Stonewood Road Baltimore, Md. 21212

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Maryland 21212

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-09

D. STREET ADDRESS (If rural, give location): 1400 Stonewood Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	Nov. 2, 1876	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dressmaker	-	Deltaville, Va.	USA

13. FATHER'S NAME: Richard C. Jackson

14. MOTHER'S MAIDEN NAME: Isabelle Hart

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	--	212-12-6348	Cordelia Reisinger (Daughter)	Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Arteriosclerosis-

DUE TO

(B) Senility-

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 10 1966 to Feb. 19 1967, that (I) (we) last saw the deceased alive on Feb 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Anthony F. Carozza M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb 20 1967

23C. PHYSICIAN'S NAME (Type): Anthony F. Carozza M.D.

23D. ADDRESS: 5217 York Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/23/1967	Clarksburg Cemetery	Amburg, Va.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 21 1967	Robert E. Farber M.D.	Eugenia K. Seitz	5209 York Rd.

Seitz Funeral Home Balto. Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

G-140

BIRTH NO. 67 1728

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1728

1. NAME OF DECEASED (Type or Print): JESSIE ALICE GABLE

2. DATE AND HOUR PRONOUNCED DEAD: February 16, 1967 3:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Pennsylvania B. COUNTY: York

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): York V-35

D. STREET ADDRESS (If rural, give location): 1401 Whiterose Lane

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: April 13, 1883

9. AGE (In years last birthday): 83

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Editor

10B. KIND OF BUSINESS OR INDUSTRY: Publications

11. BIRTHPLACE (State or foreign country): Dennison, Mo.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joshua Weeks

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 495 01 9499

17. INFORMANT: Mrs. Peggy Sieling ADDRESS: 1401 Whiterose Lane York, Penna.

MEDICAL CERTIFICATION

1B. 4221

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

DATE SIGNED: 2/17/67

23A. BURIAL CREMATION, REMOVAL (Specify): Removal-Cremation

23B. DATE: Febr 20, 1967

23C. NAME of CEMETERY or CREMATORY: Elmwood Crematory

23D. LOCATION (City, town, or county) (State): Kansas City, Missouri.

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Jacob Hartenstein

ADDRESS: New Freedom, Pa.

VS 151-REV. 1/1/65

1967 0 0 1732

W-357
B-220

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1729

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1729

1. NAME OF DECEASED (Type or Print): JOSEPH BUCZKOWSKI WITTNER

2. DATE AND HOUR OF DEATH: FEB. 20, 1967 9:A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2027 EASTERN AVE. BALTO. MD. 21231

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 2-03

D. STREET ADDRESS (If rural, give location): 2027 EASTERN AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M.	W	DIVORCED	11-22-95	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	IRON WORKS	MARYLAND	U.S.A.

13. FATHER'S NAME: JACOB BUCZKOWSKI

14. MOTHER'S MAIDEN NAME: ANNIE FROST

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-07-5196

17. INFORMANT: ANN THELEN ADDRESS: 2027 EASTERN Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ACUTE

DUE TO Cardiac-vascular arteriosclerosis

(B) Chronic Emphysema — 2 yrs

DUE TO

(C) Decompensated Heart — 6 mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from June 19 66 to Feb-20, 19 67, that (I) (~~we~~) last saw the deceased alive on Feb. 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Israel J. Feinglas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): I. J. FEINGLAS M.D.

23D. ADDRESS: 2000 E. Pratt St

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
CREMATION	2-21-67	GREEN MOUNT CREMATORY	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 21 1967	[illegible]	W. FIALKOWSKI	2007 EASTERN Ave.

Wm. Fialkowski 21231

VS 150-REV. 1/1/65

F-455

BIRTH NO. 67 1730

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1730

1. NAME OF DECEASED (Type or Print): WILLIAM FLEMING

2. DATE AND HOUR OF DEATH: 2-19-67 | 3:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 14-01

D. STREET ADDRESS (If rural, give location): 1819 Bolton St

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12-18-04

9. AGE (In years last birthday): 62

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffer

10B. KIND OF BUSINESS OR INDUSTRY: Truck Driver

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Molly Flemming

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 217-09-2260

17. INFORMANT: Mrs Corine Flemmings

ADDRESS: 1126 Forest St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 331 X 260 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-10 1967 to 2-19 1967, that (I) (we) last saw the deceased alive on 2-19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-19-67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: University Hosp Balt Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/24/67

24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry

24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Faber M.D.

25C. FUNERAL DIRECTOR: Adolphus Halstead

ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1731 Registered No. 67 1731

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FOX, WILLIE B.

2. DATE AND HOUR OF DEATH: 2/18/67 10:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-07

D. STREET ADDRESS (If rural, give location): 409 N. Edgewood St.

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed.

8. DATE OF BIRTH: 4-4-72

9. AGE (In years last birthday): 94

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): S. CAROLINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Needam Fox

14. MOTHER'S MAIDEN NAME: Rose Ann

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ETHEL McIVER ADDRESS: 409. N. EDGEWOOD ST.

MEDICAL CERTIFICATION

18. 331K

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CEREBRO VASCULAR ACCIDENT

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 3 Days.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2 - 16 - 1967 to 2 - 18 - 1967, that (I) (we) last saw the deceased alive on 2 - 18 - 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Biswanath Pillai M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): V. BISWANATH PILLAI M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/24/67

24C. NAME of CEMETERY or CREMATORY: St Johns Church Cemetry

24D. LOCATION (City, town, or county) (State): Florence S Carolina

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Ralph E. Fogle

25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

5-530

67 1732

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1732

1. NAME OF DECEASED (Type or Print): James Smith

2. DATE AND HOUR PRONOUNCED DEAD: 2/18/67 10:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1839 Aisquith St.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09

D. STREET ADDRESS (If rural, give location): 1839 Aisquith St.

5. SEX: male

6. RACE: colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated

8. DATE OF BIRTH: 2/2/38

9. AGE (In years last birthday): 28

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Samuel Wilson

14. MOTHER'S MAIDEN NAME: Dora Haskins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Dora Haskins ADDRESS:

MEDICAL CERTIFICATION

1B. E 977.9

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Unspecified drug poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1839 Aisquith Street 9-09

21D. TIME OF INJURY (APPROX.) (Month) 2 (Day) 18 (Year) '67 (Hour) a m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? ingestion of drug.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 2/19/67

23A. BURIAL CREMATION, REMOVAL (Specify): Cremation

23B. DATE: 2/22/67

23C. NAME of CEMETERY or CREMATORY: Greenmount Cemetry

23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

N 977 09 67 0 0 0 1 7 3 6

BIRTH NO. 67 1733

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1733

1. NAME OF DECEASED (Type or Print): Benjamin Franklin Chaffman

2. DATE AND HOUR OF DEATH: 2/20/67 | 8 00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-08

D. STREET ADDRESS (If rural, give location): 604 Gutman Ave.

5. SEX: M

6. RACE: Cau

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 6/8/83

9. AGE (In years last birthday): ~~xxxxx~~ 83

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Painter ~~xxxxxxxxxxxxxx~~

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Willard F. Chaffman 3332 Payne St. Balto. Md.

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E900.0

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypostatic stasis

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture Shaft Rt. Femur

CERTIFICATION APPROVED BY: Marshall Warner M.D. CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ✓

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 604 Gutman ave. 9-08

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1/19/67 2 00 PM

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR? Fell down stairs

22. I certify that (I) (this hospital) attended the deceased from 1/19 19 67 to 2/20 19 67, that (I) (we) last saw the deceased alive on 2/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R Hults M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): DR. RICHARD HULTS

23D. ADDRESS: Union Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/24/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: R. Robert E. Fisher M.D.

25C. FUNERAL DIRECTOR: Leonard J. Buck Inc. Balto. Md.

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Approved and Released by Medical Examiner 2/20/67 C.E. Benjegerdes M.D.

C-155

W-425

BIRTH NO. 67 1734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1734

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILKINSON, PAUL JUDSON

2. DATE AND HOUR OF DEATH: 19 Feb. 67 | 6 25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: ~~BALTIMORE~~

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-12

D. STREET ADDRESS (If rural, give location): ROLAND PARK APTS 514

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 10-06-93

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LAWYER

10B. KIND OF BUSINESS OR INDUSTRY: TITLE GUARANTEE CO

11. BIRTHPLACE (State or foreign country): POCOMOKE CITY Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN LLOYD WILKINSON

14. MOTHER'S MAIDEN NAME: JENNIE MATTHEWS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): YES ~~WWI~~ WW I

16. SOCIAL SECURITY NO.: 216-09-1438

17. INFORMANT: MRS. GLADYS A. WILKINSON ADDRESS: (SAME)

MEDICAL CERTIFICATION

18. 451X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Renal FAILURE — 1 week

DUE TO

(B) Dissecting Abd ANURYSM — 15 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4 Feb 1967 to 19 Feb 1967, that ~~(I)~~ (we) last saw the deceased alive on 19 Feb 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Sidney E. Kirkley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 19 Feb 67

23C. PHYSICIAN'S NAME (Type): SIDNEY E. KIRKLEY M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/1967

24C. NAME of CEMETERY or CREMATORY: Chester

24D. LOCATION (City, town, or county) (State): Chestertown, Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto. 12, Md.

1967 0 0 1 7 3 8

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1735 Registered No. 67 1735

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA R. LANGE

2. DATE AND HOUR OF DEATH: February 20, 1967. 6 30/A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1540 Kingsway Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218 27-09

D. STREET ADDRESS (If rural, give location): 1540 Kingsway Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: January 17, 1871.

9. AGE (In years last birthday): 96

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: A. Long

14. MOTHER'S MAIDEN NAME: Sophia Scheider

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Miss Lillian M. Lange ADDRESS: (Same)

MEDICAL CERTIFICATION

18. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CORONARY THROMBOSIS

DUE TO

(B) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

DUE TO

(C) ARTERIOSCLEROSIS GENERALIZED

INTERVAL BETWEEN ONSET AND DEATH: SUDDEN / YEARS (?)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from FEBRUARY 6, 1967 to FEBRUARY 20, 1967, that (I) (~~we~~) last saw the deceased alive on FEBRUARY 6, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Arthur Karfgin M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): ARTHUR KARFGIN M.D.

23D. ADDRESS: 1532 HAVENWOOD ROAD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/67.

24C. NAME of CEMETERY or CREMATORY: Maple Hill Cemetery

24D. LOCATION (City, town, or county) (State): Evansville, Wisconsin.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1736 Registered No. 67 1736

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GRACE I. RODENHI

2. DATE AND HOUR OF DEATH: 2/20/67 | 1:45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 48 Md Gen Hospital

(If not in hospital or institution, give street address or location): Balto Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. # 21218 9-06

D. STREET ADDRESS (If rural, give location): 1935 E. 31ST. ST

5. SEX: 89 F 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED 8. DATE OF BIRTH: 11/11/78 9. AGE (In years last birthday): 89 If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Md. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES WINKLEMAN 14. MOTHER'S MAIDEN NAME: KATE LAMBERT.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-22-4577 17. INFORMANT: Kenneth R Koskinen MD ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — 4 days.

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. urinary tract infection

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/16 19 67 to 2/20 19 67, that (I) (we) last saw the deceased alive on 2/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R Koskinen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): Kenneth R. Koskinen M.D. 23D. ADDRESS: Md. Gen Hosp Balto, md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2/22/67. 24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967 25B. NAME OF REGISTRAR: [illegible] 25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-314

BIRTH NO. 67 1737

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1737

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): THELMA ROSE STAPLETON

2. DATE AND HOUR OF DEATH: Feb. 21, 1967 | 3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gould Convalesarium 6116 Belair Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 6902 Ridgeway Road

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Sept. 17, 1894.

9. AGE (In years last birthday): 72

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Weldon

14. MOTHER'S MAIDEN NAME: Mary G. Foard

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 321-18-9223A

17. INFORMANT: Rev. J. Gordon Stapleton, ADDRESS: 1500 Bradford Rd. Wilmington, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) 443X Hypertensive Arteriosclerotic Cardio-vascular disease

DUE TO (B) Associated Parkinsonism

(C)

INTERVAL BETWEEN ONSET AND DEATH: 20 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Multiple decubitus ulcers, stage to viscera

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan. 5 1967 to Feb. 21 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 20 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: H. V. Harbold M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb. 21, 1967

23C. PHYSICIAN'S NAME (Type): Dr. Harold V. Harbold M.D.

23D. ADDRESS: 4706 Harford Rd., Balto., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/67.

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Falkenstein

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.-Baltimore, Md.-14 ADDRESS

VS 150-REV. 1/1/65

1 7 9 1

T-520

BIRTH NO. 67 1738

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1738

1. NAME OF DECEASED (Type or Print): LEE I. THOMAS

2. DATE AND HOUR OF DEATH: Feb. 17 67 | 11:05 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 HARFORD GARDENS CONV.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 27-07
D. STREET ADDRESS (If rural, give location): 2801 FLEETWOOD AVE

5. SEX: M.
6. RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 12/31/02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINTANCE MAN.
10B. KIND OF BUSINESS OR INDUSTRY: Sheppard Pratt.
11. BIRTHPLACE (State or foreign country): OKLAHOMA.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Wm.
14. MOTHER'S MAIDEN NAME: Unknown.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 217-26-0408
17. INFORMANT: WIFE
ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 1808 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypernephroma, Left — 1 year

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 19 67 to Feb 17 19 67, that (I) (~~we~~) last saw the deceased alive on February 17 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Loy M. Zimmerman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Feb 20, 67
23C. PHYSICIAN'S NAME (Type): Loy M. Zimmerman M.D.
23D. ADDRESS: 3202 Harford Rd, Baltimore Md.

24A. BURIAL CREMATION REMOVAL (Specify): BURIAL
24B. DATE: Feb 21, 67
24C. NAME of CEMETERY or CREMATORY: GARDENS OF FAITH.
24D. LOCATION (City, town, or county) (State): BALTO Co.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Hardwicke
25C. FUNERAL DIRECTOR: P. A. Heemann
ADDRESS: 6067 HARFORD Co.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-151

BIRTH NO. 67 1739

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1739

1. NAME OF DECEASED (Type or Print): HEFFNER, ETHEL

2. DATE AND HOUR OF DEATH: 18 FEB. 1967 6 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3618 MANCHESTER AVE

00 BALTIMORE, 15 MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: SAME B. COUNTY: BALTO. CITY Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE - 27-18

D. STREET ADDRESS (If rural, give location): 3618 MANCHESTER AVE.

5. SEX: F

6. RACE: Wh

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 30 ~~MAY~~ JUNE 1895

9. AGE (In years last birthday): 71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (State or foreign country): RIGA LATVIA

12. CITIZEN OF WHAT COUNTRY? YES USA

13. FATHER'S NAME: JACOB BLAKE

14. MOTHER'S MAIDEN NAME: UNKNOWN.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: H. WALEN M.D. ADDRESS: SINAI HOSP

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) HASCVD — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not ~~While At Work~~ ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 14 Feb 1967 to 17 Feb 1967, that (I) (we) last saw the deceased alive on 17 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harry M. Walen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 18 FEB '67

23C. PHYSICIAN'S NAME (Type): HARRY M. WALEN M.D.

23D. ADDRESS: SINAI HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 19 2/18/67

24C. NAME of CEMETERY or CREMATORY: ANSHE NEISEN Hebrew Long

24D. LOCATION (City, town, or county) (State): Rosedale Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Taylor-Lewis Inc. ADDRESS: 210 Eutaw St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-256

BIRTH NO. 67 1740

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1740

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary O'Connor

2. DATE AND HOUR PRONOUNCED DEAD: 2/18/67 | 2:05 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: Union Memorial Hospital

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-06

D. STREET ADDRESS (If rural, give location): 514 W. 33rd St.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: May 2,1901

9. AGE (In years last birthday): 65

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Supervisor

10B. KIND OF BUSINESS OR INDUSTRY: Coady & Farley

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: John T. O'Connor

14. MOTHER'S MAIDEN NAME: Elmira McClelland.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: David P. Connor.Sr.

ADDRESS: 2932 Huntingdon Ave

MEDICAL CERTIFICATION

1B. 381.1

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute ethylism

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/18/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/21/67

23C. NAME of CEMETERY or CREMATORY: New Cathedral

23D. LOCATION (City, town, or county) (State): Old Frederick Rd, Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Austin E. Donovan

ADDRESS: 3818 Roland Ave

VS 151-REV. 1/1/65

1967 0001744

H-553

BIRTH NO. 67 1741

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1741

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HAMMOND, WINFIELD ATHEY

2. DATE AND HOUR OF DEATH: 19 Feb 67 | 11 55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEM. HOSP.

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-09
D. STREET ADDRESS (If rural, give location): 1639 WINFORD ROAD

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 08-22-93
9. AGE (In years last birthday): 73
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED BARBER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CLINTON HAMMOND
14. MOTHER'S MAIDEN NAME: SARAH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Unk. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: MINNIE R. HAMMOND — ADDRESS: 1639 WINFORD RD

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRAGE — 4 days

DUE TO

(B) HYPERTENSION — yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. aspiration pneumonia

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from Feb 16 1967 to Feb 15 1967, that ~~(I)~~ (we) last saw the deceased alive on Feb 15 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Sidney E. Kirkley M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 19 Feb 67
23C. PHYSICIAN'S NAME (Type): Dr Sidney E. Kirkley M.D.
23D. ADDRESS: The Union Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/67
24C. NAME of CEMETERY or CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Windsor Mill Rd, Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Barbaro
25C. FUNERAL DIRECTOR: Clayton E. Donovan — ADDRESS: 3818 Roland Ave

VS 150-REV. 1/1/65

48-65-86 IB C-450

BIRTH NO. 67 1742

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1742

RELEASED ON APPROVAL BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): CLINE CLARA

2. DATE AND HOUR OF DEATH: 2/17/67 3:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-08
D. STREET ADDRESS (If rural, give location): 3428 MT. PLEASANT AVENUE - #21224

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 11-9-81
9. AGE (In years last birthday): 85
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM
14. MOTHER'S MAIDEN NAME: ANNIE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: #21224 RECORDS-BCH-4940 EASTERN AVENUE, ADDRESS

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH: Respiratory arrest. + Cardiac Arrest. Secondary to laryngeal edema. — INTERVAL BETWEEN ONSET AND DEATH: 30'

(A) DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

E903.0

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
- (R) Hip Fracture.
- (L) Lower Lobe Pneumonia
- Fleas
- Diabetes
- HBP
- ASCVD.

10 days

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER M.D. 2/21/67

19A. DATE OF OPERATION: 2/9/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: (R) Hip Fx
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☒
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home.
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Home.
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour): 2/7/67
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒
21F. HOW DID INJURY OCCUR? accidentally Fell down

22. I certify that (I) (this hospital) attended the deceased from 2/7/67 to 2/17/67, that (I) (we) last saw the deceased alive on 2/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pablo Trefogli M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/17/67
23C. PHYSICIAN'S NAME (Type): PABLO TREFOGLI M.D.
23D. ADDRESS: BCH 4940 EASTERN AVENUE Baltimore, Md. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cem
24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Joseph W. Zannino, Jr.
ADDRESS: 263 S Conkling

VS 150-REV. 1/1/65

N 82.00 / 0 0 / 7 7 7

C-4510

Released by medical examiner on approval

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1743 Registered No. 67 1743

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Chlan Mr. Charles H.

2. DATE AND HOUR OF DEATH: 2-19-67 7 15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 21207 Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 1914 Park Place.

5. SEX: M. 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married 8. DATE OF BIRTH: 06-27-86 9. AGE (In years last birthday): 80 If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk Retired 10B. KIND OF BUSINESS OR INDUSTRY: Parts Wholesale

11. BIRTHPLACE (State or foreign country): ~~Baltimore~~ Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Anton Chlan. 14. MOTHER'S MAIDEN NAME: Anna Lippa

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-07-0016A

17. INFORMANT: Raymond Chlan, son, 142 Regester Ave. ADDRESS 21212

MEDICAL CERTIFICATION

1B. 4 2 2 1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Laryngo Tracheo Bronchitis

DUE TO (B) ~~Arteriosclerotic cardiovascular~~ ~~heart disease~~ Aspiration Regurgitated Contents ~~Pulmonary atelectasis~~ (L)

DUE TO (C) A. S. C.V.D. ~~Bronchopneumonia~~

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Right hip fracture

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER. M.D.

19A. DATE OF OPERATION: 3 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Hip nailing (R) (1-26-67) 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ ☑

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1914 Park Place

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1-25-67 1 PM 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑ 21F. HOW DID INJURY OCCUR? FELL BACKWARD IN BATHROOM

22. I certify that (I) (this hospital) attended the deceased from 1-25-67 19 to 2-19 19 67, that (I) (we) last saw the deceased alive on 2-19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nabil J. Warsal M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 2-19-67

23C. PHYSICIAN'S NAME (Type): Nabil J. Warsal M.D. 23D. ADDRESS: Maryland Gen. Hosp

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2/23/67 24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967 25B. NAME OF REGISTRAR: Robert E. Tarkington 25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65 1967000 1718

Dr Fischer

K-530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1744 Registered No. 67 1744

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANTON KNOTT

2. DATE AND HOUR OF DEATH: February 20, 1967 | 8:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen. Hospital 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 21220 Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 643 New Section Road, Apt. #15

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH: 7-23-02

9. AGE (In years last birthday): 64

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal None

10B. KIND OF BUSINESS OR INDUSTRY: Lloyd E. Mitchell Co

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rudolph Knott

14. MOTHER'S MAIDEN NAME: ~~xxxxxxxxxx~~ Rosa Kuzak (nee Dashner)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-05-4868

17. INFORMANT: Elizabeth Knott ADDRESS: wife Same

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

CAUSE OF DEATH

(A) Arrhythmia

DUE TO

Myocardial infarction

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 10 1967 to February 20 1967, that (I) (we) last saw the deceased alive on Feb. 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Holadom Sabundayo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Feb. 20, 1967

23C. PHYSICIAN'S NAME (Type): Rolando M. Sabundayo M.D.

23D. ADDRESS: Md. Gen. Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Tasker M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-621

BIRTH NO. 67 1745

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1745

1. NAME OF DECEASED (Type or Print): GEORGE HENRY KIRKPATRICK, SR

2. DATE AND HOUR OF DEATH: Feb. 18, 1967 8:30 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3403 Kenyon Ave. Baltimore, Md. 21213

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03

D. STREET ADDRESS (If rural, give location): 3403 Kenyon Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 2/12/1908

9. AGE (In years last birthday): 59

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Security Guard

10B. KIND OF BUSINESS OR INDUSTRY: E.J.Korvette

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Kirkpatrick

14. MOTHER'S MAIDEN NAME: Mary Snyder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes

(If yes, give war or dates of service): W.W. 2

16. SOCIAL SECURITY NO.: 212-05-5860

17. INFORMANT: Sadie Sclereth Kirkpatrick, wife, above

ADDRESS:

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I 1B. 16GX DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of the lung	4 mo.
	DUE TO (B)	
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Coronary disease	2 yrs

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 2-16 1958 to 2-18 1967, that (I) (we) last saw the deceased alive on 2-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Duer Moores M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2-20-67

23C. PHYSICIAN'S NAME (Type): Dr. J. Duer Moores M.D.

23D. ADDRESS: 3105 Belair Rd.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: 2331 Brehms Lane

VS 150-REV. 1/1/65

1967 00 1750

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1746 Registered No. 67 1746

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HERMAN MICHEL

2. DATE AND HOUR OF DEATH: Feb. 18, 1967 11 p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 House in the Pines Belair Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Md. 21213
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03
D. STREET ADDRESS (If rural, give location): 3609 Lyndale Ave.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 1/2/1875
9. AGE (In years last birthday): 92
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales
10B. KIND OF BUSINESS OR INDUSTRY: L.A.Benson
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Michel
14. MOTHER'S MAIDEN NAME: Katherine Weiss

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-05-8064
17. INFORMANT: Catherine M. Haneke, dght, above
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.2

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — 7 days

DUE TO

(B) Hypertension — 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Myocardial Insufficiency — Months

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Brain Syndrome — Years

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 7/31/1964 to 2/18/1967, that (I) (~~we~~) last saw the deceased alive on 2/17 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did not) view the body after death.

23A. SIGNATURE: Albert B Bradley M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/20/67
23C. PHYSICIAN'S NAME (Type): Dr. Albert B. Bradley M.D.
23D. ADDRESS: 4900 Belair Road

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/67
24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3381 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-6.4b

BIRTH NO. 67 1747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1747

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Biaggio Giorilli

2. DATE AND HOUR OF DEATH: 2-18-1967 | 8:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 3-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore # 21202

D. STREET ADDRESS (If rural, give location): 211 So. High Street.

5. SEX: M.

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married.

8. DATE OF BIRTH: 8-10-82

9. AGE (In years last birthday): 84.

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction

10B. KIND OF BUSINESS OR INDUSTRY: John Sullivan Co. Retired.

11. BIRTHPLACE (State or foreign country): Italy.

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Constandino.

14. MOTHER'S MAIDEN NAME: Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-03-3989

17. INFORMANT: Serafina DiBona Siorgilli, wife, above — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
420.1	(A) Terminal Bronchial pneumonia	days
	(B) DUE TO ? Myocardial Infarct	days
	(C) ASCVDs	Years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Uraemia

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 2-8 19 67 to 2-18 19 67, that ~~I~~ (we) last saw the deceased alive on 2-18 19 67 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rifat Al-Abousy M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-18-67

23C. PHYSICIAN'S NAME (Type): Rifat Al-Abousy M.D.

23D. ADDRESS: 1213 hight Street.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR — ADDRESS: Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1748 Registered No. 67 1748

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gosnell Charles

2. DATE AND HOUR OF DEATH: 2-19-67, 8 35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 7-02

D. STREET ADDRESS (If rural, give location): 730 N. KENWOOD AVENUE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWER

8. DATE OF BIRTH: 7-17-85

9. AGE (In years last birthday): 81

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret-Dipper

10B. KIND OF BUSINESS OR INDUSTRY: Balto. Enamel Works

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: CHARLES Hartman

14. MOTHER'S MAIDEN NAME: CARRIE Gosnell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-5930

17. INFORMANT: Emma Lawrence, friend, above

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 493X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Pneumonia — 3 days

DUE TO

(B) Chronic Obstructive Lung Disease — ~5 years

DUE TO

(C) ASCVD — ~5 years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

AS & AI

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 2-14 1967 to 2-18 1967, that (we) last saw the deceased alive on 2-18 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.

23A. SIGNATURE: Stephen W. Spaulding M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/18/67

23C. PHYSICIAN'S NAME (Type): DR. STEPHEN W. SPAULDING. M.D.

23D. ADDRESS: JHH

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: 2601 E. Madison St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

46-69-77
IW N-630

BIRTH NO. 67 1749

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1749

1. NAME OF DECEASED (Type or Print): ELIZABETH NORWOOD

2. DATE AND HOUR OF DEATH: 2-19-67 | 6 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 6-02
D. STREET ADDRESS (If rural, give location): 437 N GLOVER STREET - 21224

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED
8. DATE OF BIRTH: 1/15/16
9. AGE (In years last birthday): 51
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Receptionist
10B. KIND OF BUSINESS OR INDUSTRY: Dr.J.S.McClees
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: DANIEL CADDEN
14. MOTHER'S MAIDEN NAME: ELIZABETH REMLEIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-26-5557
17. INFORMANT: RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 — ADDRESS

MEDICAL CERTIFICATION

18. 286.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Chronic Malnutrition
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: ? yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible sepsis; Probable intracranial mass lesion

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-13 1967 to 2-19 1967, that (I) ~~(we)~~ last saw the deceased alive on 2-19 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: James T. Corkins M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-19-67
23C. PHYSICIAN'S NAME (Type): JAMES T. CORKINS M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTO., MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/67
24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. — ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-36b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1750 Registered No. 67 1750

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SOPHIA M. STURGEON

2. DATE AND HOUR OF DEATH: Feb. 17, 1967 | 6 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4751 Elison Ave., Baltimore, Md., 21206

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-02

D. STREET ADDRESS (If rural, give location): 4751 Elison Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	widowed	1/7/82	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Baltimore, Md.	

13. FATHER'S NAME: John L. Berger

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-2993 D

17. INFORMANT: Peter Albert-son-in-law, above ADDRESS:

MEDICAL CERTIFICATION

1B. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardio Renal failure

DUE TO

(B) due to Arteriosclerotic Cardio-Vascular disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 11/25 1963 to Feb. 17 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 15 1967 and that in (~~my~~) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (did ~~not~~) view the body after death.

23A. SIGNATURE: L B Stevens M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/18/67

23C. PHYSICIAN'S NAME (Type): Dr. L. B. Stevens M.D.

23D. ADDRESS: 3400 Erdman Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/20/67	Baltimore Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

6 7 0 0 1 7 5 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-60

BIRTH NO. 67 1751

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1751

1. NAME OF DECEASED (Type or Print): Rosamond Josephine Mora

2. DATE AND HOUR OF DEATH: Feb. 16, 1967 | 8:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital, Wyman Pk. Drive & 31st Street

28

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03
D. STREET ADDRESS (If rural, give location): 3067 Mayfield Ave.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 9/8/15
9. AGE (In years last birthday): 51
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: 217-05-9498
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elmer Lindemore
14. MOTHER'S MAIDEN NAME: Elizabeth M. ~~Culber~~ Culver

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Records- US PHS Hospital, Balto, Md.
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 1251 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Gastrointestinal hemorrhage — 1 day

DUE TO

(B) Metastatic adenocarcinoma rt. fallopian tube — 22 mos.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I)/(this hospital) attended the deceased from Jan. 3 1967 to Feb. 16 1967, that (I)/(we) last saw the deceased alive on Feb. 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Morton Axelrod M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X ☐
23B. DATE SIGNED: 2/17/67
23C. PHYSICIAN'S NAME (Type): Morton Axelrod, Surgeon (R) M.D.
23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: Moreland Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 21 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

W-234

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1752 Registered No. 67 1752

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WASTLER, LLOYD

2. DATE AND HOUR OF DEATH: 2/16/67 11:10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md GEN HOSP. BALTO., Md

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 53-00
D. STREET ADDRESS (If rural, give location): 1641 Yakona Rd

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 2/7/1904
9. AGE (In years last birthday): 63
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FLORIST
10B. KIND OF BUSINESS OR INDUSTRY: Nursery
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: NEWTON WASTLER
14. MOTHER'S MAIDEN NAME: MOLLIE HUBAGGER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-01-3917
17. INFORMANT: Kenneth R Koskinen MD ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. E-9020

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) POLYCYTHEMIA — 2 YRS

DUE TO

(B) CHRONIC BRONCHITIS & EMPHYSEMA — 10 YRS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD & secondary CHF

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/11/67 19 to 2/16 19 67, that (I) (we) last saw the deceased alive on 2/16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R. Koskinen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/16/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Md Gen Hosp. BALTO., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Pk.
24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: William E. Johnson ADDRESS: 8521 Lochraven Blvd.

VS 150-REV. 1/1/65

M-452 1

BIRTH NO. 67 1753

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1753

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dennis Mullins

2. DATE AND HOUR PRONOUNCED DEAD: 2/17/67 10:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 800 S. Broadway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-03

D. STREET ADDRESS (If rural, give location): 800 S. Broadway

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): DIVORCED

8. DATE OF BIRTH: UNK

9. AGE (In years last birthday): 66

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY: AUTO INDUST

11. BIRTHPLACE (State or foreign country): WISE CO VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: UNK

14. MOTHER'S MAIDEN NAME: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 407-07-8611

17. INFORMANT: HARLIS MULLINS ADDRESS: 1916 E BALTIMORE ST

MEDICAL CERTIFICATION

18. 422.1 I 00 8.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary tuberculosis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: 2/18/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: FEB 21 1967

23C. NAME of CEMETERY or CREMATORY: ST PAULS CEMETERY

23D. LOCATION (City, town, or county) (State): 5600 CARDIFF AVE MD

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

24B. NAME OF REGISTRAR: Robert E. Faulkner

24C. FUNERAL DIRECTOR: DIPPEL BROS INC ADDRESS: 1800 E LOMBARD ST

VS 151-REV. 1/1/65

1967 0001758

M: 5341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1754 Registered No. 67 1754

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mendeloff Dr. Morris I.

2. DATE AND HOUR OF DEATH: 2/15/67 4.45 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — NAME OF HOSPITAL OR INSTITUTION (If not hospital or institution, give street address or location): Sinai Hospital

CERTIFICATE AMENDED 2/23/67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. VA
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): CHARLESTON
D. STREET ADDRESS (If rural, give location): 5222 [redacted] Ave. KNAWHA S.E.

V-45

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 11/10/87
9. AGE (In years last birthday): 79 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10B. KIND OF BUSINESS OR INDUSTRY: Internist
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW 1 Army
16. SOCIAL SECURITY NO.: 233-56-0449
17. INFORMANT: ESTHER - WIFE — ADDRESS: SAME

MEDICAL CERTIFICATION

1B. 200.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hepato-renal failure — 2 weeks

~~UREMIA~~

DUE TO

(B) Lymphosarcoma of portal area & kidneys — ? months

~~Chronic Pyelonephritis~~ ~~Past months~~

DUE TO

(C) Retroperitoneal Lymphosarcoma — ? months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia. Partial thrombosis of inferior vena cava. Coronary heart disease

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/25 1967 to 2/15 1967, that (I) (we) last saw the deceased alive on 2/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Eduardo Hidalgo M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): EDUARDO HIDALGO M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial-Removal
24B. DATE: 2/19/67
24C. NAME of CEMETERY or CREMATORY: Bnai Israel
24D. LOCATION (City, town, or county) (State): Cemetery Hill, Charleston, W. VA.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., ADDRESS: 6010 Reisterstown

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter dated 2/20/67 from Dr.Pyoung Kwon, Resident, Dept.of Medicine and Dr.Seana W.Quinton, Asst.Pathologist, Dept.of Pathology of Sinai Hospital re changes as indicated on reverse side.

L-520

BIRTH NO. 67 1755

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 372 056 67 1755

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LYONS LOUIS S

2. DATE AND HOUR OF DEATH: 2.15.67 | 11.55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 2714 Oswego Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 3.10.1890
9. AGE (In years last birthday): 76 yrs
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: Benjamin Lyons
14. MOTHER'S MAIDEN NAME: Rose ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-03-2601
17. INFORMANT: Mr. Albert Lyons, 6617 Shelrick Place #9
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 157X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) peripheral Circulatory failure — 5 days
DUE TO
(B) Collapse + pneumothorax of lung
DUE TO Spontaneous Hemo-pneumothorax
(C) metastatic Carcinoma of pancreas

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2.10 1967 to 2.15 1967, that (I) (we) last saw the deceased alive on 2.15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: M Schwendors M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-15.67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/17/67
24C. NAME of CEMETERY or CREMATORY: Anshe Emunah - (Aitz Chaim)
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Faber M.D.
26C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.
ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

R-324

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1756 Registered No. 67 1756

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ADDYE M. ROTHSCHILD

2. DATE AND HOUR OF DEATH: February 14, 1967 | 5 p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodmount Apartments 6528 Park Heights Avenue, Apt C

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): Woodmount Apts., 6528 Park Heights Avenue, C

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	July 25, 1882	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore, Maryland	USA

13. FATHER'S NAME: Jacob Moses

14. MOTHER'S MAIDEN NAME: Carrie Stern

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-48-4067

17. INFORMANT: Miss Dorothy Baum, 6528 Park Heights Avenue — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~DUE TO~~ Hypernephroma — INTERVAL BETWEEN ONSET AND DEATH: 9 months

(B) DUE TO Arteriosclerosis

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 1945 19 to Feb 14 1967, that (I) ~~(we)~~ last saw the deceased alive on Feb. 11 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We) (did)~~ (did not) view the body after death.

23A. SIGNATURE: Louis Hamburger M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/15/67

23C. PHYSICIAN'S NAME (Type): Dr. Louis Hamburger M.D.

23D. ADDRESS: 1001 St. Paul Street

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/17/67	Hebrew Friendship	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Farbman	Sol Levinson & Bros. Inc.	6010 Reist., Rd.

VS 150-REV. 1/1/65

1
S-416

67 1757

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1757

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Hannah Silberschmidt

2. DATE AND HOUR PRONOUNCED DEAD 2/20/67 7:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-01

D. STREET ADDRESS (If rural, give location) 903 Lake Dr.

5. SEX female

6. RACE white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married

8. DATE OF BIRTH Jan. 25, 1882

9. AGE (In years last birthday) 85 85

If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Silberschmidt

14. MOTHER'S MAIDEN NAME Babette Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-44-0513

17. INFORMANT Miss Ruth F. Ring ADDRESS Mulberry Apts.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. E812.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~DUE TO~~ Bronchopneumonia complicating multiple injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Clovverdale Rd. and Druid Hill Dr. 13-03

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 2 13 67 10:45 a.m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? pedestrian struck by truck

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF M.D. Werner U. Spitz

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED 2/21/67

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 2/22/67

23C. NAME of CEMETERY or CREMATORY Oheb Shalom

23D. LOCATION (City, town, or county) (State) 6130 O'Donnell St. Balto. Md.

24A. DATE REC'D BY HEALTH DEPT. FEB 23 1967

24B. NAME OF REGISTRAR Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR Jack Lewis, Inc. ADDRESS 2100 Eutaw Place

VS 151-REV. 1/1/65

N869.2 / 0001762

M-635

67-03603

BIRTH NO. 67 1758

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1758 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARTIN, TAMMY JEAN

2. DATE AND HOUR OF DEATH: 2/19/67 | 10:12 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto. Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Dundalk 53-00
D. STREET ADDRESS (If rural, give location): 7864 St. Fabian Lane

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 2/19/67
9. AGE (In years last birthday): ~~XXXXXX~~ 8 hours
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours: 8 | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Bernard E. Martin
14. MOTHER'S MAIDEN NAME: Judy Diane Small, 7864 St. Fabian Lane

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT:
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 773.65 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RESPIRATORY DISTRESS SYND — ~8h.
DUE TO

(B) PREMATURITY 26-28wk BIRTH WT 1100gm
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/19 1967 to 2/19 1967, that (I) (we) last saw the deceased alive on 2/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: James Sobel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/19/67
23C. PHYSICIAN'S NAME (Type): James Sobel M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/21/67
24C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fulkerson
25C. FUNERAL DIRECTOR: HOWARD H. HUBBARD
ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

M-324

BIRTH NO. 67 1759

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1759

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mitchell, Francis Leroy

2. DATE AND HOUR OF DEATH: February 19, 1967 | 8:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, maryland 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2736 Maryland Ave.

12-06

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 4/10/~~97~~ 98
9. AGE (In years last birthday): ~~69~~ 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Salesman~~ Estimator
10B. KIND OF BUSINESS OR INDUSTRY: Jarboe Bros.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: John T. Mitchell
14. MOTHER'S MAIDEN NAME: Emma M. Wonder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 9/5/18-8/28/19
16. SOCIAL SECURITY NO.: 218-09-87-43
17. INFORMANT: Veterans Hospital Records, BALTO., MD.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

200.1

(A) Lymphosarcoma, suspected — INTERVAL BETWEEN ONSET AND DEATH: 1 Month

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Arteriosclerosis — Years

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 14, 1967 to February 19, 1967, that (I) (we) last saw the deceased alive on February 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Barry N. Rosenbaum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: 2-20-67
23C. PHYSICIAN'S NAME (Type): Barry N. Rosenbaum M.D.
23D. ADDRESS: VAH, Baltimore, Md. 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: HOWARD H. HUBBARD
ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

1967 0 0 1 7 5 9

B-6210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1760 Registered No. 67 1760

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Cecelia E. Bark

2. DATE AND HOUR OF DEATH: Feb. 17, 1967 | 5-30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Goulds

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 1-02

D. STREET ADDRESS (If rural, give location): 20 S. Curley St.

5. SEX: F. 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): 8. DATE OF BIRTH: 11-19-1895 9. AGE (In years last birthday): 71 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Md. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry 14. MOTHER'S MAIDEN NAME: Jungkowski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-01-1336 17. INFORMANT: Wm. Bark Jr. ADDRESS: 3608 Fostel Ave.

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary artery disease
DUE TO Generalized Art. Sclerosis
Gangrene of leg

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 1965 to 2/17 1967, that (I) (we) last saw the deceased alive on 2/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. H. Goodman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 2/17/67

23C. PHYSICIAN'S NAME (Type): J. H. Goodman M.D. 23D. ADDRESS: 3400 E. Balto St Balto Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2-21-67 24C. NAME of CEMETERY or CREMATORY: Oak Lawn 24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967 25B. NAME OF REGISTRAR: Robert E. Jackson 25C. FUNERAL DIRECTOR: Hoffman Funeral Home ADDRESS: 3218 Hudson St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-350

Delaware 67 1761

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1761

THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

1. NAME OF DECEASED (Type or Print): Christie Stanwar

2. DATE OF DEATH: 2/16/67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): James Lawrence Kernan Hospital

93

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Owings Mills 53-00
D. STREET ADDRESS (If rural, give location): Rosewood State Hosp.

5. SEX: F
6. COLOR OR RACE: Caucasia
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 6/5/60
9. AGE (In years last birthday): 6 yr
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10.A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Kathy Stanwar

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital
ADDRESS: Chart.

MEDICAL CERTIFICATION

18. 344.2

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Herniation of Temporal lobes — INTERVAL BETWEEN ONSET AND DEATH: few days

DUE TO

(B) Internal and External hydro-

DUE TO cephalus.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II
19A. DATE OF OPERATION: 1/9/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Subluxation Left Hip
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/1 19 66 to 2/16 19 67, that (I) (we) last saw the deceased alive on 2/15 19 67, and that in (my) (our) opinion death occurred at 3:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Lawrence F. Monch M. D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
23B. ADDRESS: J. L. Kernan Hosp. Baltimore, Md
23C. DATE SIGNED: 2/16/67

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/20/67
24C. NAME OF CEMETERY OR CREMATORY: Rosewood Cemtery
24D. LOCATION (City, town, or county) (State): Owings Mills, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Farkey
25C. FUNERAL DIRECTOR: J. F. Eline & Sons
ADDRESS: Reisterstown, Md.

VS 150

1967 0001766

B-630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1762 | Registered No. 67 1762

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANK S. BRADY SR.

2. DATE AND HOUR OF DEATH: FEB. 17. 1967 | 1 30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GOULD 90 CONVALESCARIUM

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): LUTHERVILLE — 53-00
D. STREET ADDRESS (If rural, give location): 135 DUBLIN DRIVE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWER
8. DATE OF BIRTH: 12/16/88
9. AGE (In years last birthday): 78 yrs.
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10B. KIND OF BUSINESS OR INDUSTRY: FOOD —
11. BIRTHPLACE (State or foreign country): VIRGINIA —
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN CALVIN BRADY
14. MOTHER'S MAIDEN NAME: ALMA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 248-07-1510
17. INFORMANT: Frank A. Brady Jr.
ADDRESS: LUTHERVILLE

MEDICAL CERTIFICATION

18. I. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cecum — 1 year

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(1) Arteriosclerotic C-V disease — 5 years
(2) Tuberculous Cystitis — 1 year

19A. DATE OF OPERATION: DEC 16 - 66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CA of Cecum
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1940 19 to FEB 17 1967, that (I) (~~we~~) last saw the deceased alive on FEB 12 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: George Sawyer M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Feb. 17 - 67

23C. PHYSICIAN'S NAME (Type): GEORGE SAWYER M.D. M.D.
23D. ADDRESS: 4808 Harford Rd. - Balto 14 MD

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb 20 67
24C. NAME of CEMETERY or CREMATORY: Friends Cem.
24D. LOCATION (City, town, or county) (State): Fallston Harford Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Ralph E. Fahey M.D.
25C. FUNERAL DIRECTOR: W. H. Archer
ADDRESS: Benson Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-30D

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1763

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1763

1. NAME OF DECEASED (Type or Print): EDWARD H. ROTH

2. DATE AND HOUR OF DEATH: FEB. 17, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31/99 D.O.A. City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 211 MARLYN AVE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: JAN. 18, 1914
9. AGE (In years last birthday): 53 YRS.
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RECISION
10B. KIND OF BUSINESS OR INDUSTRY: MARTIN CO.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: EDWARD H. ROTH
14. MOTHER'S MAIDEN NAME: EMMA C. HARTLINE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-09-1824
17. INFORMANT: MRS EMMA M. ROTH
ADDRESS: 211 MARLYN AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Myocardial Infarction — 1/2 hour
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/14/1962 to 2/17/1967, that (I) (we) last saw the deceased alive on 2/17/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hea Rean LEW M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/20/67
23C. PHYSICIAN'S NAME (Type): Hea Rean LEW M.D.
23D. ADDRESS: 417 1/2 Eastern Blvd, Baltimore 21

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-22-67
24C. NAME of CEMETERY or CREMATORY: GARDEN OF FAITHS CEM
24D. LOCATION (City, town, or county) (State): BALTIMORE MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Foley M.D.
25C. FUNERAL DIRECTOR: Raymond L. Raczkowski
ADDRESS: 2525 Fleet St

VS 150-REV. 1/1/65

W-220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1764 Registered No. 67 1764

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Wysocki - Hiley Louis J.

2. DATE AND HOUR OF DEATH: February 19, 1967 | 9 : 45 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-01

D. STREET ADDRESS (If rural, give location): 102 N. Potomac Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	8/26/1912	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	--	Pennsylvania	U.S.A.

13. FATHER'S NAME: Joseph Wysocki

14. MOTHER'S MAIDEN NAME: Anna Reppy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-09-2875

17. INFORMANT: Patient Himself ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

(B) congestive heart failure

DUE TO

(C) arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12/20/1965	arteriosclerosis	Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 3 19 66 to February 19, 19 67, that (I) (we) last saw the deceased alive on February 19, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Manuel J. Tan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: February 19, 1967

23C. PHYSICIAN'S NAME (Type): Manuel J. Tan M.D.

23D. ADDRESS: Church Home and Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/23/1967	St. Stanislaus Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Fisher M.D.	John A. Moran Inc.	3000 E. Baltimore St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1765 Registered No. 67 1765

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BURRIER, ROGER DEAL

2. DATE AND HOUR OF DEATH: 2-20-67 | 6 00/A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIV. HOSP. 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: Frederick Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): MT. AIRY 60-00
D. STREET ADDRESS (If rural, give location): ROUTE 4

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NM
8. DATE OF BIRTH: 8-18-03
9. AGE (In years last birthday): 63
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EMERSON D. BURRIER
14. MOTHER'S MAIDEN NAME: Edith GERTRUDE GARVER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-40-6678
17. INFORMANT: ADELENE BURRIER ADDRESS: S/A

MEDICAL CERTIFICATION

18. 593 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) RENAL FAILURE

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. STROKE

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/2 1967 to 2/20 1967, that (I) (we) last saw the deceased alive on 2/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stuart L. Fine M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/20/67
23C. PHYSICIAN'S NAME (Type): STUART L. FINE M.D.
23D. ADDRESS: UNIV. HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/23/1967
24C. NAME of CEMETERY ~~or CREMATORY~~: Frederick Memorial Park
24D. LOCATION (City, town, or county) (State): Frederick, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: C. M. Waltz ADDRESS: Box 241 Sykesville, Md.

VS 150-REV. 1/1/65

1967 0 0 1 7 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-23

BIRTH NO. 67 1766

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1766

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): REBECCA WACHTER

2. DATE AND HOUR OF DEATH: FEB 20, 1967 | 5 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 JEWISH CONV. HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-10

D. STREET ADDRESS (If rural, give location): 4009 W. COLDSPRING LANE

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: AUG 1891

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): POLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LOUIS

14. MOTHER'S MAIDEN NAME: ESTHER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: SAMUEL WACHTER

ADDRESS: SAME

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Diffuse cerebral arteriosclerosis

DUE TO Coronary arteriosclerosis

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Mar 1965 19 to 2/20/67 19, that (I) (we) last saw the deceased alive on 2/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/29/67

23C. PHYSICIAN'S NAME (Type): Milton B. Kirsh, M.D.

23D. ADDRESS: 4000 W. Northern Pkwy - Baltimore - 21215

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Herring Run

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Fabian M.D.

25C. FUNERAL DIRECTOR: Sylvan S. Lewis & Son

ADDRESS: Harrison, Md

VS 150-REV. 1/1/65

1771

M-240

BIRTH NO. 67 1767

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1767

1. NAME OF DECEASED (Type or Print): DAISY BEATRICE MAXWELL

2. DATE AND HOUR OF DEATH: 2-18-67 | 5:02 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE [redacted] B. COUNTY W. VA.

C. CITY OR TOWN (If outside city limits, write RURAL and give township) [redacted] FOLLANSBEE

D. STREET ADDRESS (If rural, give location): 214 S. MAIN ST. V-45

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-07-93

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM SUTHERIN

14. MOTHER'S MAIDEN NAME: MARY GRIMM

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 272 28 6639A

17. INFORMANT: CHART

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Esophagobronchial fistula c

DUE TO

(B) ~~and~~ aspiration.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

4 K. Kim

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-16 19 67 to 2-18 19 67, that (I) ~~(we)~~ last saw the deceased alive on 2-18 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Frank A. Carozza M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-18-67

23C. PHYSICIAN'S NAME (Type): FRANK A. CAROZZA M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: Union Cemetery

24D. LOCATION (City, town, or county) (State): Steubenville, Ohio

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Phillips & Gerach

ADDRESS: 1211 Chesapeake Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1768 Registered No. 67 1768

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WRAGG SARAH

2. DATE AND HOUR OF DEATH: 2/20/67 11 35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-01
D. STREET ADDRESS (If rural, give location): 1507 N. Carey St. #17

5. SEX: female
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M.
8. DATE OF BIRTH: 6-9-14
9. AGE (In years last birthday): 52
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ← Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BEN MAYBANKS
14. MOTHER'S MAIDEN NAME: Kate Gibbs

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Major Wragg ADDRESS: 1507 N. Carey St.

MEDICAL CERTIFICATION

18. I 420.0 + 171X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute pulm. edema — 1 hour
DUE TO
(B) Left heart failure — hrs.
DUE TO
(C) ASHD — unk.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Squamous cell carcinoma of the cervix stage II, extreme obesity

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 5 PM 2/20 1967 to 11:35 PM 2/20 1967, that (I) ~~(we)~~ last saw the deceased alive on 2/20 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/20/67
23C. PHYSICIAN'S NAME (Type) M.D.:
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/25/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Jackson
25C. FUNERAL DIRECTOR: George H. Kelar ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1769 Registered No. 67 1769

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edward Graham

2. DATE AND HOUR OF DEATH: 2/22/67 2:20 PM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: 2142 W. Lexington Street. 10-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Maryland 21223

D. STREET ADDRESS (If rural, give location): 2142 Lexington St.

5. SEX: MALE

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 5-27-1905

9. AGE (In years last birthday): 61

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Longshoreman

11. BIRTHPLACE (State or foreign country): Payton S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Candis Graham ADDRESS: 2142 W. Lexington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular accident — 7 years

DUE TO

(B) Renal failure

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FEB. 12 1967 to FEB. 22 1967, that (I) (we) last saw the deceased alive on FEB 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jose T. Villa Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-22-67

24C. NAME of CEMETERY or CREMATORY: Mt. Calvery Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: R. R. E. Fadyma

25C. FUNERAL DIRECTOR: Kalson Funeral Home ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

W-325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1770 Registered No. 67 1770

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGIA A. WATKINS

2. DATE AND HOUR OF DEATH: 2-26-67 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 CARVER NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 17-01

D. STREET ADDRESS (If rural, give location): 607 Pennsylvania Avenue

5. SEX: F.

6. RACE: N.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: April 24, 1895

9. AGE (In years last birthday): 71

If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MECHARRIN, VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN FOSTER

14. MOTHER'S MAIDEN NAME: LOUISE FOSTER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Clarence Foster ADDRESS: 4012 Carlisle Ave

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

334X + 260X

(A) Cerebral Vascular Disease — Unknown

DUE TO

(B) Chronic Glomerulonephritis — Unknown

DUE TO

(C) Gangrene of Left Foot — 2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 12/15 1960 to 2/16 1967, that (I) (~~we~~) last saw the deceased alive on 2/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: E E Holt M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): E. E. Holt M.D.

23D. ADDRESS: 3715 Liberty Hts. Ave., Balto., Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-22-67

24C. NAME of CEMETERY or CREMATORY: Mount Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto., Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Morton & Dyett F.H. ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
F-200

67 1771

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

Registered No. 67 1771

1. NAME OF DECEASED (Type or Print): ETHEL FOUCH

2. DATE AND HOUR PRONOUNCED DEAD: February 20, 1967 8:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital (DOA)

39/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

13-04

D. STREET ADDRESS (If rural, give location): 2309 Reisterstown Road

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 6-20-1917

9. AGE (In years last birthday): 49

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home.

11. BIRTHPLACE (State or foreign country): Property S. Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elliott Moon

14. MOTHER'S MAIDEN NAME: Vinnie Moonie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT: Robert Fouch ADDRESS: 2309 Reisterstown Rd.

MEDICAL CERTIFICATION

18. E903.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary embolus complicating

DUE TO fracture of left fibula

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): (in front of) Ruskin and 2285 Reisterstown Road

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-9-67 8:00 A.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR?: Slipped on ice

13-04

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: RSFisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: February 20, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2-24-67

23C. NAME of CEMETERY or CREMATORY: Arbutus

23D. LOCATION (City, town, or county) (State): Arbutus Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

24B. NAME OF REGISTRAR: [illegible]

24C. FUNERAL DIRECTOR: Morton + Dyett

ADDRESS: 1701 Laurens St.

VS 151-REV. 1/1/65

N 23 [illegible] 0 0 1 7 7 6

K-656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1772 Registered No. 67 1772

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE J. KREMER

2. DATE AND HOUR OF DEATH: February 22, 1967 | 9:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-11

D. STREET ADDRESS (If rural, give location): 619 S. Clinton Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	June 30, 1895	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Bread Salesman	Baltimore, Maryland	

13. FATHER'S NAME: Theodore Kremer

14. MOTHER'S MAIDEN NAME: Catherine Donnley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 1	215-05-3366	Mrs. Teresa Kremer	619 S. Clinton St.

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thrombosis — Instantaneous

DUE TO Myocardial Infarction

(B) Coronary Arteriosclerosis Disease — Unknown

DUE TO

(C) Emphysema — 10 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/11 1962 to 2/22 1967, that (I) (we) last saw the deceased alive on 2/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Henry J. Houska M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): HENRY J. HOUSKA M.D.

23D. ADDRESS: 333 S. EAST AVE BALTO - MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-25-1967	Sacred Heart	Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Fabian	Lilly & Zeiler Inc.	1901-07 Eastern Ave.

VS 150-REV. 1/1/65

Robert E. Fabian 67 1772

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-263

BIRTH NO. 67 1773

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1773

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James J. McGrath Jr.

2. DATE AND HOUR PRONOUNCED DEAD: 2/19/67 1:05 a.m.

CERTIFICATE AMENDED 2-23-67

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1107 HARRITON RD. 00 ~~1107 Harrington Rd.~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-13
D. STREET ADDRESS (If rural, give location): 1107 Harrington Rd. HARRITON

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: Nov. 11, 1911
9. AGE (In years last birthday): ~~XX~~ 55
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10B. KIND OF BUSINESS OR INDUSTRY: Attorney
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James J. McGrath Sr.
14. MOTHER'S MAIDEN NAME: Agatha Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Merza L. McGrath ADDRESS: 1107 Harriton Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E916.0 + 522.0

(A) Smoke and soot inhalation associated with carbon monoxide poisoning

~~DUE TO~~

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Ethylism

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1107 Harrington Rd. 27-13

21D. TIME OF INJURY (APPROX.) (Month) 2 (Day) 19 (Year) 67 (Hour) 12:50 a.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR?: Conflagration

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 2/19/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/21/67
23C. NAME of CEMETERY or CREMATORY: Cathedral
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
24B. NAME OF REGISTRAR: Robert E. Faber M.D.
24C. FUNERAL DIRECTOR: H.W. Mears & Son
ADDRESS: 805 N. Calvert St.

VS 151-REV. 1/1/65

N968.3 6.7 0 0 0 1 7 7 8

Letter from M.E.'s office 2-23-67 M.H.

E-461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1774 Registered No. 67 1774

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM R. ELLERBE

2. DATE AND HOUR OF DEATH: 2-19-67 | 7 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 5-01
D. STREET ADDRESS (If rural, give location): 1237 E. MONUMENT STREET

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	COLORED	DIVORCED	9-5-00	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-03-7406

17. INFORMANT: EMMA JOHNSON ADDRESS: 1517 E. LANVALE ST

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ventricular fibrillation — 18 hours

DUE TO

(B) Myocardial infarction

DUE TO

(C) CVA

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart Failure

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/18 1967 to 2/19 1967, that (I) (we) last saw the deceased alive on 2/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John S. Sargent M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/19

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-23-67

24C. NAME of CEMETERY or CREMATORY: MT AUBURN

24D. LOCATION (City, town, or county) (State): BALTIMORE MD.

25A. DATE RECEIVED BY HEALTH DEPT. FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Kimmert & Joseph Knight Funeral Home ADDRESS: 1639 N. Broadway

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-640

Approved by Dr. R. Doyle 2/20/67

Released by Medical Examiners Office

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-28740 67 1775 Registered No. 67 1775

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VERONICA FERRELL

2. DATE AND HOUR OF DEATH: 2/20/67 4:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP. 44 N. CALVERT & 33rd ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: BALTIMORE 007

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE. Zone 18

D. STREET ADDRESS (If rural, give location): 3330 Robb ~~Ave~~ St

5. SEX: Female 6. RACE: Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single 8. DATE OF BIRTH: 11-20-65 9. AGE (In years last birthday): 15 mo. If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 10B. KIND OF BUSINESS OR INDUSTRY: None 11. BIRTHPLACE (State or foreign country): BALTIMORE Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SALONE FERRELL 14. MOTHER'S MAIDEN NAME: Cledi Ferrell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT: Mother ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute bronchopneumonia

DUE TO

(B) Acute leukemia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

A. Vignolito, M.D.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/20/67 2:45 PM 19 67 to 2/20/67 4:35 PM 19 67, that (I) (we) last saw the deceased alive on 2/20/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert P. Doyle M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): ROBERT P. DOYLE M.D. 23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL 24B. DATE: 2-24-67 24C. NAME of CEMETERY or CREMATORY: MT. AUBURN 24D. LOCATION (City, town, or county) (State): BALTIMORE Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: Joseph Knight Funeral Home ADDRESS:

VS 150-REV. 1/1/65

S-425

BIRTH NO. 67 1776

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1776

1. NAME OF DECEASED (Type or Print): Salganik, Mollie E.

2. DATE AND HOUR OF DEATH: 2/20/67 | 3:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Balt.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt.

D. STREET ADDRESS (If rural, give location): 2604 KEYWORTH AVENUE

15-12

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): m

8. DATE OF BIRTH: 3/18/98

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): ? NEW HAMPSHIRE

12. CITIZEN OF WHAT COUNTRY? ? USA

13. FATHER'S NAME: PHILIP COHEN ?

14. MOTHER'S MAIDEN NAME: ? REBECCA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): ?

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Husband MR. DAVID SALGANIK, ADDRESS: 3210 BONNIE ROAD

MEDICAL CERTIFICATION

1B. 260 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Failure.

DUE TO

(B) Shock +

DUE TO

(C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/19 19 67 to 19 , that (I) (we) last saw the deceased alive on 2/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. J. Moglen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): L. J. Moglen M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: SHAAREI ZION

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Ralph E. Jackson

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-420

67 1777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1777

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): SURASKY, DAVID

2. DATE AND HOUR OF DEATH: 2.20.67 | 11 07 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL of Balto. Inc. Greenspring at Belvedere Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location): 6111 Benhurst ROAD

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4.11.05
9. AGE (In years last birthday): 61
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - PROPRIETOR
10B. KIND OF BUSINESS OR INDUSTRY: MEAT & GROCERYS
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: JOSEPH SURASKY
14. MOTHER'S MAIDEN NAME: SEVA FUCHS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: MRS. MARY SURASKY, ADDRESS: 6111 BENHURST ROAD #9

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 181.7

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute myocardial infarction — 15 min
DUE TO
(B) Metastatic carcinoma — 1 yr
DUE TO
(C) Primary urinary tract neoplasm

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 0
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): no
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1964 to Feb 20 1967, that (I) (we) last saw the deceased alive on Feb 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Maurice Feldman Jr M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Feb 20, 1967
23C. PHYSICIAN'S NAME (Type): DR. MAURICE FELDMAN, JR. M.D.
23D. ADDRESS: LATROBE BUILDING

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/21/67
24C. NAME of CEMETERY or CREMATORY: LORRAINE (MAUSOLEUM)
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fogelman
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

K-620

BIRTH NO. 67 1778

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1778

1. NAME OF DECEASED (Type or Print): KRAUSE, MARY V.

2. DATE AND HOUR OF DEATH: FEBRUARY 21, 1967 2.50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21227 53-00

D. STREET ADDRESS (If rural, give location): 5532 COUNCIL ST.

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 8-22-94

9. AGE (In years last birthday): 72

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES WIEGAND

14. MOTHER'S MAIDEN NAME: Dorothea [illegible] WIEGAND SNYDER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NONE (If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO. 215-10-2178

17. INFORMANT: ST. AGNES HOSPITAL RECORDS ADDRESS: 21229

MEDICAL CERTIFICATION

18. 527.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Marked pulmonary emphysema & fibrosis DUE TO

(B) COPD DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 10 19 67 to FEBRUARY 21 19 67, that (I) (we) last saw the deceased alive on FEBRUARY 21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-21-67

23C. PHYSICIAN'S NAME (Type): MIGUEL HERECIA M.D.

23D. ADDRESS: ST. AGNES HOSP; CATON & WILKENS AVES.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-24-67

24C. NAME of CEMETERY or CREMATORY: Meadowridge Cemetery

24D. LOCATION (City, town, or county) (State): Howard County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Howard H. Hubbard ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

H-625

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1779 Registered No. 67 1779

M.E. CASE NO. 66-25509

1. NAME OF DECEASED (Type or Print): BARBARA K. HARRISON

2. DATE AND HOUR PRONOUNCED DEAD: February 20, 1967 10:22 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Hopkins Hospital (DOA)

33/89

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore # 21205. 26-44
D. STREET ADDRESS (If rural, give location): 1038 Iris Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Nov. 27, 1966
9. AGE (In years last birthday): If Under 1 Yr. Months: 2 Days: 23 Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Douglas V. Harrison
14. MOTHER'S MAIDEN NAME: Frances Shook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Douglas V. Harrison
ADDRESS: Same.

MEDICAL CERTIFICATION

18. 525X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonitis (SDII)
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R R Fisher M.D.
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: February 20, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-21-67
23C. NAME of CEMETERY or CREMATORY: Mt. Carmel Cemetery
23D. LOCATION (City, town, or county) (State): 5712 O'Donnell St. Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
24B. NAME OF REGISTRAR: R. E. Fisher M.D.
24C. FUNERAL DIRECTOR: Charles A. Geiter
ADDRESS: 6224 Eastern Ave. Balto., 21224, Md.

VS 151-REV. 1/1/65

1967000178 4

B-60D

BIRTH NO. 67 1780

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1780

1. NAME OF DECEASED (Type or Print): GEORGE G. BAUER

2. DATE AND HOUR OF DEATH: FEB. 21, 1967 | 8¹⁵ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): N. CHARLES GEN. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-10
D. STREET ADDRESS (If rural, give location): 7 S. EAST STR. #24

5. SEX: M.
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5/31/1894
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED, STANDARD OIL
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH BAUER
14. MOTHER'S MAIDEN NAME: MARGARET HOLSTEIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNKNOWN (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-01-4288
17. INFORMANT: NORTH CHARLES GENERAL HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 420.1

(A) MYOCARDIAL INFARCTION

DUE TO

(B) ARTERIOSCLEROTIC HEART DIS.

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): O
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/5/ 1967 to 2/21 1967, that (I) (we) last saw the deceased alive on 2/21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert Roubenoff M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/21/67
23C. PHYSICIAN'S NAME (Type): ROBERT ROUBENOFF M.D.
23D. ADDRESS: N. CHARLES GEN. Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/25/67
24C. NAME of CEMETERY or CREMATORY: MEADOWRIDGE CEM.
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Farber
25C. FUNERAL DIRECTOR: B. DABROWSKI
ADDRESS: 2814 E. BALTIMORE ST.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 1000 1780

35-86-00
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1781 Registered No. 67 1781

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James A. Zelenka

2. DATE AND HOUR OF DEATH: 2-19-67 6 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4940 EASTERN AVENUE - 21224
26-12 BALTO. CITY HOSPITALS

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: Sept 4 '97
9. AGE (In years last birthday): 69
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance
10B. KIND OF BUSINESS OR INDUSTRY: Packing House
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wenceslaus Zelenka
14. MOTHER'S MAIDEN NAME: ~~Beatrice Potrotka~~ Maria SoFe

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216 03 3865
17. INFORMANT: RECORDS: BCH, 4940 Eastern Avenue, Balto. Md. 21224
ADDRESS:

MEDICAL CERTIFICATION

18. 450.1 I — 008.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO
(B)

DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
TB, infected gangrene

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-3-62 19 to 2-19-67 19, that (I) (we) last saw the deceased alive on 2-18-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2-19-67
23C. PHYSICIAN'S NAME (Type): V. J. Felitti, M.D.
23D. ADDRESS: BCH, 4940 Eastern Avenue, Balto. Md. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Stanley M.D.
25C. FUNERAL DIRECTOR: Philip E. Crock
ADDRESS: 1211 Chesaco Ave.

VS 150-REV. 1/1/65

D-452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1782 Registered No. 67 1782

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Flossie I. Dowling

2. DATE AND HOUR OF DEATH: February 20, 1967 | 8:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 Saint Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Maryland, Anne Arundel Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Linthicum, Heights 32-00
D. STREET ADDRESS (If rural, give location): 1221 Furnace Rd.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	8/25/07	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Ports

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-52-9677

17. INFORMANT: William E. Dowling, Sr. ADDRESS: 1221 Furnace Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Coronary Thrombosis — 1 day
DUE TO
(B) Chr Myocarditis — 4 yrs
DUE TO
(C) Toxic Goitre — 5 yrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 13 1967 to Feb 20 1967, that (I) (~~we~~) last saw the deceased alive on Feb 20 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B. B. Brumbaugh M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): Dr. Bruce B. Brumbaugh M.D.

23D. ADDRESS: 5609 Main St., Elkridge

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/67

24C. NAME of CEMETERY or CREMATORY: Meadowridge Cemetery

24D. LOCATION (City, town, or county) (State): Dorsey, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Faber

25C. FUNERAL DIRECTOR: Ambrose, Inc. ADDRESS: 1328 Sulphur Spring Rd

VS 150-REV. 1/1/65 67 0 0 1 7 8 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-640

BIRTH NO. 67 1783

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 1783

1. NAME OF DECEASED (Type or Print): BIRLEY, GLEN M.

2. DATE AND HOUR OF DEATH: 2-20-67 | 2 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DEAD ON ARRIVAL BY AMBULANCE at UNIV. HOSPITAL, BALTO. MD

38/19

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: HARFORD Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): CARDIFF 62-00
D. STREET ADDRESS (If rural, give location): CHESTNUT

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: JULY 29, 1914
9. AGE (In years last birthday): 52
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANAGER
10B. KIND OF BUSINESS OR INDUSTRY: QUARRY
11. BIRTHPLACE (State or foreign country): BLUE RIDGE SUMMIT, PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES H. BIRLEY
14. MOTHER'S MAIDEN NAME: NETTIE MILLER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO. 162-05-9634
17. INFORMANT: MRS. GLEN M. BIRLEY
ADDRESS: CARDIFF, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: HODGKIN'S DISEASE — INTERVAL BETWEEN ONSET AND DEATH: ± 5 years.

(B) DUE TO:

(C):

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from July 1962 19 to Feb. 20 19 67, that (I) ~~(we)~~ last saw the deceased alive on Feb. 14 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Morris J. Wizenberg M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-20-67
23C. PHYSICIAN'S NAME (Type): MORRIS J. WIZENBERG M.D.
23D. ADDRESS: UNIVERSITY WIZENBERG

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-23-67
24C. NAME of CEMETERY or CREMATORY: SLATE RIDGE
24D. LOCATION (City, town, or county) (State): DELTA, YORK Co., PA.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: John H. Harding
ADDRESS: DELTA, PA.

VS 150-REV. 1/1/65

967000170 A

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-261

BIRTH NO. 67 1784

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1784

1. NAME OF DECEASED (Type or Print): MR LEONHARDT REISER (LEONHARD)

2. DATE AND HOUR OF DEATH: FEB. 22nd 1967 | 10:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: THE UNION MEMORIAL HOSPITAL

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CALVERT & 33rd ST. BALTIMORE

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTIMORE 22-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21230
D. STREET ADDRESS (If rural, give location): 635 PORTLAND STREET

5. SEX: M
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~MARRIED~~
8. DATE OF BIRTH: 07-21-90
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barrell Business
10B. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? AMERICA.

13. FATHER'S NAME: JOHN M. REISER SR.
14. MOTHER'S MAIDEN NAME: ANOTTA M. ~~[illegible]~~ ROTHLINGHOFER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ~~[illegible]~~ (If yes, give war or dates of service): W.W. I
16. SOCIAL SECURITY NO.: 212-18-8719
17. INFORMANT: ELIZABETH R. ~~[illegible]~~ GALTON (SISTER) ADDRESS: 648 Coleraine Rd

MEDICAL CERTIFICATION

1B. 260 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Occlusion (R) coronary artery — INTERVAL BETWEEN ONSET AND DEATH: 8 Days

DUE TO

(B)

DUE TO

(C) diabetes mellitus — 2 years +

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 02-15 1967 to 02-22 1967, that (I) (we) last saw the deceased alive on FEB. 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Roy S. Patten M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: FEB. 22-1967
23C. PHYSICIAN'S NAME (Type): ROY S. PATTEN, JR. M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/25/67
24C. NAME of CEMETERY or CREMATORY: London Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: John J. Conway Sr. Inc.
ADDRESS: 901 Hollins St. (Balto. Md. 21223)

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-55D

67 1785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1785

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): George M Penning

2. DATE AND HOUR OF DEATH: Feb 20 1967 | 4:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 217 W 27th St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-06
D. STREET ADDRESS (If rural, give location): 217 W 27th St

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: JAN 3 1885
9. AGE (In years last birthday): 82
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Floor Layer
10B. KIND OF BUSINESS OR INDUSTRY: Flooring
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218 09 6207
17. INFORMANT: Ada F. Penning — ADDRESS: 217 W 27th St 21211

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

(B) Generalized arteriosclerosis — 4 years

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coma unconscious 2 days. Old Stroke Old M.I.

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Sept 1964 to Feb 20 1967, that (~~I~~) (we) last saw the deceased alive on Feb 20 1967 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Herman Brecher M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/21/67
23C. PHYSICIAN'S NAME (Type): HERMAN BRECHER M.D.
23D. ADDRESS: 443 E. 25th St. Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-23-67
24C. NAME of CEMETERY or CREMATORY: Louden Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Burgee Funeral Home — ADDRESS: 3631 Falls Rd

VS 150-REV. 1/1/65

1967 0 Bd Health Baltimore Md

E-66B

Joseph Mann Earhart

BIRTH NO. 67 1786

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1786

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JOSEPH MANN EARHART

2. DATE AND HOUR OF DEATH: 2-15-67 4 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 The Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-08 D. STREET ADDRESS (If rural, give location): 1214 Union Avenue

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 12-14-84

9. AGE (In years last birthday): 82 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10B. KIND OF BUSINESS OR INDUSTRY: Navy Yard

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Elmer Earhart

14. MOTHER'S MAIDEN NAME: Josephine Marrigan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212305905

17. INFORMANT: Helen Miller — ADDRESS: 3313 Spulding Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1

(A) Atherosclerotic Cardio vascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 21-10-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gangrene (R) foot

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-22 1966 to 2-15 1967, that (I) (we) last saw the deceased alive on 2-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Felix J Martin M.O. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-15-67

23C. PHYSICIAN'S NAME (Type): FELIX J. MARTIN, M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/18/67

24C. NAME of CEMETERY or CREMATORY: Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Foley M.D.

25C. FUNERAL DIRECTOR: Burgee Funeral Home — ADDRESS: 3631 Falls Rd

Burgee

VS 150-REV. 1/1/65

K-600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1787 Registered No. 67 1787

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Miss Olverta Frost Karr

2. DATE AND HOUR OF DEATH: Feb. 16, 1967 | 5:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-07

D. STREET ADDRESS (If rural, give location): 3631 Elm Ave.

5. SEX: Female

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: 11/21/81

9. AGE (In years last birthday): 85

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper

10B. KIND OF BUSINESS OR INDUSTRY: Plumber

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T. Karr

14. MOTHER'S MAIDEN NAME: Susan Y. Burns

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218 01 7172

17. INFORMANT: Mrs. Oda L. Garrett ADDRESS: Same

MEDICAL CERTIFICATION

1B. 442X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) A.S.C.V.D. - Nephrosclerosis — years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 2/15 1967 to 2/16 1967, that (I) ~~(we)~~ last saw the deceased alive on 2/16 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Nat E. Watson, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/16/67

23C. PHYSICIAN'S NAME (Type): DR NAT E WATSON M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-20-67

24C. NAME of CEMETERY or CREMATORY: Lorraine Park

24D. LOCATION (City, town, or county) (State): Woodlawn, Balto Co Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Rd

Balto Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1788 Registered No. 67 1788

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): UNDERHILL DR. JOHN M.

2. DATE AND HOUR OF DEATH: 2.19.67 12:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 28-31

D. STREET ADDRESS (If rural, give location): 6610 Vincent Lane #15

5. SEX: MALE

6. RACE: CAUCASIAN

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 10.5.1896

9. AGE (In years last birthday): 70 — If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOCTOR

10B. KIND OF BUSINESS OR INDUSTRY: MEDICINE

11. BIRTHPLACE (State or foreign country): Landsdowne, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN UNDERHILL

14. MOTHER'S MAIDEN NAME: ALICE HICKS ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-20-9452

17. INFORMANT: MARY - WIFE. ADDRESS: 6610 VINCENT LANE #15

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: CARDIAC ARREST — 2 days

(B) DUE TO: FRACTURE LEFT HIP.

(C): ACUTE MYOCARDIAL INFARCTION

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

E904.0

CERTIFICATION APPROVED BY: CHIEF OR ASST. MEDICAL EXAMINER. 2/20/67

19A. DATE OF OPERATION: 2.18.67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: traumatic left hip

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☑

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Home in Bedroom 28-31

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2.17.67

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑

21F. HOW DID INJURY OCCUR? FELL ACCIDENTALLY.

22. I certify that (I) (this hospital) attended the deceased from 2.17.67 19 to 2.19 1967, that (I) (we) last saw the deceased alive on 2.19.67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: CCRao M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ House

23B. DATE SIGNED: 2.19.67

23C. PHYSICIAN'S NAME (Type): Dr C. C. RAO M.D.

23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: WOODLAWN CEMETERY

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Lankey M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

N 820.8

TO BE APPROVED BY FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1789

BIRTH NO.

M.E. CASE NO. 67 1789

1. NAME OF DECEASED (Type or Print): FANNY OFSHITZER

2. DATE AND HOUR OF DEATH: 2-17-67 | 2:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE BALTO, MD. 42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: ~~[illegible]~~ B. COUNTY: Canada

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Montreal V-50

D. STREET ADDRESS (If rural, give location): 6760 Westbury Avenue

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: —

9. AGE (In years last birthday): 77

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home.

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME: Moses Shulman

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Mr. Ben Wexler, 3724 Fieldstone Road #21133 — ADDRESS

MEDICAL CERTIFICATION

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) CVA

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from Feb. 16 1967 to Feb 17 1967, that (I) (we) last saw the deceased alive on Feb. 14 1967 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-17-67

23C. PHYSICIAN'S NAME (Type): L. E. VENTURANZA M.D.

23D. ADDRESS: Sinai Hospital of Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/19/67

24C. NAME of CEMETERY or CREMATORY: Canada Hebrew Sick Benefit Society

24D. LOCATION (City, town, or county) (State): Dele Savanne, Montreal

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., 6010 Reisterstown — ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-b-46

BIRTH NO. 67 1790

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1790

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Florence P. Kessler

2. DATE AND HOUR OF DEATH: February 17, 1967 | 5^15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3102 Oakfield Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-09

D. STREET ADDRESS (If rural, give location): 3102 Oakfield Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: December 6, 1897

9. AGE (In years last birthday): 69

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herman Puretz

14. MOTHER'S MAIDEN NAME: Annie Kres

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mr. Charles M. Kessler, 7104 Boxford Road #15

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occl. — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1962 19 to 2/17 1967, that (I) (we) last saw the deceased alive on 2/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: R. S. Kallins M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/18/67

23C. PHYSICIAN'S NAME (Type): Dr. Edward S. Kallins M.D.

23D. ADDRESS: 4300 Liberty Heights Avenue

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/19/67

24C. NAME of CEMETERY or CREMATORY: Hebrew Friendship

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Foley M.D.

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

1975

M-260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1791 Registered No. 67 1791

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Morris Mazer

2. DATE AND HOUR OF DEATH: Feb. 19, 1967 | 11 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale, Hebrew Home and Infirmary

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-20

D. STREET ADDRESS (If rural, give location): 2501 Steele Road

91

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Single	December 26, 1914	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Retail	Russia	USA

13. FATHER'S NAME: Abraham Mazer

14. MOTHER'S MAIDEN NAME: Tina Goldenberg

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W. W. 11	213-03-0043	Mr. William Mazer	4106 Rockfield Avenue #15

MEDICAL CERTIFICATION

CAUSE OF DEATH

18.		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) metastatic carcinoma of stomach –	5 months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

151 X

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 14 1967 to Feb. 19 1967, that (I) (we) last saw the deceased alive on Feb. 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Ruth Willner M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb. 19, 1967

23C. PHYSICIAN'S NAME (Type): Ruth Willner M.D.

23D. ADDRESS: Levindale, Hebrew Home and Infirmary

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/20/67	Beth Tfiloh	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Falkenna	Sol Levinson & Bros. Inc.	6010 Reist., Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-45 D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1792 Registered No. 67 1792

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): AGNES BLANK

2. DATE AND HOUR OF DEATH: 2/19/67 | 3:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location): 3905 FORDLEIGH Rd. APT. A.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 7-17-85
9. AGE (In years last birthday): 81
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David DAVID
14. MOTHER'S MAIDEN NAME: Hermine SEELIG

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-28-0293A
17. INFORMANT: HOSPITAL CHART
ADDRESS

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Myocardial infarct.
DUE TO
(B) A.C.V.D.
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from many years 19 to 2/19/ 19 67, that (I) (we) last saw the deceased alive on 2/19/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. Weinberger M.D.
Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/19/67

23C. PHYSICIAN'S NAME (Type): R. Weinberger, M.D.
23D. ADDRESS: 3640 Fordslane Baltimore, Md 21215

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/19/67
24C. NAME of CEMETERY or CREMATORY: Chevra Ahavas Chesed
24D. LOCATION (City, town, or county) (State): Randallstown Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fagan M.D.
25C. FUNERAL DIRECTOR: Sol Leuman & Bros Inc. 6200 Reisterstown Rd.
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-62

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 · 1793 Registered No. 67 1793

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SIMHA SAMUEL KRYGER

2. DATE AND HOUR OF DEATH: ~~50~~ 2/20/67 4^45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION: Md Gen Hosp BALTO. md (If not in hospital or institution, give street address or location) 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 27-17 D. STREET ADDRESS (If rural, give location): 2909 Oakley Ave

5. SEX: M 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED 8. DATE OF BIRTH: 11-28-13 9. AGE (In years, last birthday): 53 If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [redacted] 10B. KIND OF BUSINESS OR INDUSTRY: Grocery Store 11. BIRTHPLACE (State or foreign country): Poland 12. CITIZEN OF WHAT COUNTRY? [redacted] Canadian

13. FATHER'S NAME: Hertzke [redacted] Proprietor Kryger 14. MOTHER'S MAIDEN NAME: [redacted] ? CHANA CHAI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.: UNKNOWN 17. INFORMANT: Kenneth R Kaskinen, MD ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4221

(A) cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. pneumonia — 3 days

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 02/10/67 19 to 02/20 19 67, that (I) (we) last saw the deceased alive on 02/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R Kaskinen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): KOSKINEN M.D. 23D. ADDRESS: Md Gen Hosp BALTO. md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2/20/67 24C. NAME of CEMETERY or CREMATORY: Lodger Society 24D. LOCATION (City, town, or county) (State): Montreal, Canada

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967 25B. NAME OF REGISTRAR: [illegible] 25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., 6010 Reist., Rd. ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1728

G-621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1794 Registered No. 67 1794

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GROSS HELEN T.

2. DATE AND HOUR OF DEATH: February 19, 1967 12:05 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1655 Vincent Court

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: 1655 VINCENT COURT

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, MARYLAND 15-01

D. STREET ADDRESS (If rural, give location): 1655 VINCENT COURT

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 3/22/07

9. AGE (In years last birthday): 60

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): ST. MARY"S COUNTY MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES THORNTON

14. MOTHER'S MAIDEN NAME: MARY NOEL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. No 214-3710

17. INFORMANT: Mary Gross ADDRESS: 313 Monastery Ave

MEDICAL CERTIFICATION

1B. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) MYOCARDIAL INSUFFIENCY

DUE TO

(B) HYPERTENSIVE CARDIO VASCULAR

DUE TO

(C) ARTERIOSCLEROSIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE

19A. DATE OF OPERATION: NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JUNE 15 19 60 to FEBRUARY 19 19 67, that (I) (we) last saw the deceased alive on FEBRUARY 19, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Marcus W Moore Sr M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): MARCUS W. MOORE, SR. M.D.

23D. ADDRESS: 1371 N. CAREY STREET

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: V. Brooks Lenggold ADDRESS: 1463 McCaul St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1795 Registered No. 67 1795

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John T. Ridgley Sr.

2. DATE AND HOUR OF DEATH: Feb 22, 1967 8:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2119 Eagle Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-05

D. STREET ADDRESS (If rural, give location): 2119 Eagle St.

5. SEX: M. 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married 8. DATE OF BIRTH: 6/9/1909 9. AGE (In years last birthday): 57

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Ridgley

14. MOTHER'S MAIDEN NAME: Mary Boone

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 212-07-5234

17. INFORMANT: Monica Ridgley ADDRESS: 2119 Eagle ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163 X

(A) Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: 1965

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1965 19 to February 25 1967, that (I) (we) last saw the deceased alive on Feb. 24, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Morris B. Schreiber M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2.22.67

23C. PHYSICIAN'S NAME (Type): MORRIS B. SCHREIBER M.D.

23D. ADDRESS: 1519 W. LOMBARD ST

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/25/67

24C. NAME of CEMETERY or CREMATORY: Good Shepherd Cem.

24D. LOCATION (City, town, or county) (State): Ellicott City, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Witter F.H. ADDRESS: 4101 Edmondson Ave

VS 150-REV. 1/1/65

1967 00 1800

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-531

BIRTH NO. 67 1796

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1796

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): SNYDER, CARRIE F

2. DATE AND HOUR OF DEATH: 2-22-67 1:00 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE 29, MD.

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: BALTIMORE #29
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-08
D. STREET ADDRESS (If rural, give location): 129 SO. LOUDON AVE.

5. SEX: FEMALE
6. RACE: CAUCASION
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 05 08 98
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWOFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILLIAM FRANCK (DEC'D)
14. MOTHER'S MAIDEN NAME: ELIZABETH (DEC'D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Thomas Snyder-129 S. Loudon Ave.
ADDRESS: ST. AGNES RECORDS: CATON & WILKENS AVES

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 21 19 67 to FEBRUARY 22 19 67, that (I) (we) last saw the deceased alive on FEBRUARY 22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pablo E. Dilod M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-24-67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Witzke F.D.-4101 Edmondson Ave.
ADDRESS

VS 150-REV. 1/1/65

0 1 8 0 1

B-623

BIRTH NO. 67 1797

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1797

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BURKHART WOODWARD W.

2. DATE AND HOUR OF DEATH: 2/21/67 6 10 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GEN'L HOSPITAL

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE CO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-00
D. STREET ADDRESS (If rural, give location): 2506 POPLAR DR.

5. SEX: M
6. RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 8/23/15
9. AGE (In years last birthday): 51
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER.
10B. KIND OF BUSINESS OR INDUSTRY: BALTO. GAS & ELEC.
11. BIRTHPLACE (State or foreign country): BALTO. Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: CHAS. L. BURKHART
14. MOTHER'S MAIDEN NAME: Alma L. MEYERS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-05-7342
17. INFORMANT: Mrs. Rosebud Burkhart
ADDRESS: 2506 Poplar Dr.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 153.8 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) SEPSIS — 8 hours
DUE TO
(B) PERITONITIS, GENERALIZED — 6 days
DUE TO
(C) POSSIBLE MYOCARDIAL INFARCTION. —

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/14/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CARCINOMA OF COLON
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): ~~2 11 67~~
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 2-11-67 19 to 2-21-67 19, that ~~I~~ (we) last saw the deceased alive on 2-21-67 19 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert M. Beazley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/21/67
23C. PHYSICIAN'S NAME (Type): ROBERT M. BEAZLEY M.D.
23D. ADDRESS: MARYLAND GEN'L HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-24-1967
24C. NAME of CEMETERY or CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Taylor
25C. FUNERAL DIRECTOR: G. Howard Strong
ADDRESS: 3207 W. North Ave.,

VS 150-REV. 1/1/65

0 1 8 0 2

H-670

67 1798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1798

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Harris Jr.

2. DATE AND HOUR OF DEATH: 2-19-67 | 11 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 25-32

D. STREET ADDRESS (If rural, give location): 2454 Joseph Ave.

5. SEX: Male

6. RACE: Col.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Aug 3, 1938

9. AGE (In years last birthday): 28

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Harris Sr.

14. MOTHER'S MAIDEN NAME: Frances ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-36-1235

17. INFORMANT: Delores Harris

ADDRESS: 2454 Joseph Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 603X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 39 days

DUE TO

(B) possible acute cortical necrosis of kidneys — 39 days

DUE TO

(C) Possible collagen vascular disease or glomerulonephritis — 44 days or more

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hemmorhage due to liver biopsy possibly

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 12/26 1966 to 2/19 1967, that (I) (we) last saw the deceased alive on Feb 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis E. Grenzer M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/19/67

23C. PHYSICIAN'S NAME (Type):

23D. ADDRESS: Mercy Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/1967

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: Williams Funeral Home

ADDRESS: 3197 Schroeder St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-610

BIRTH NO. 67 1799

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1799

1. NAME OF DECEASED (Type or Print): FRANK DUMONT THROOP

2. DATE AND HOUR OF DEATH: FEB. 21, 1967 | 2:25 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 4508 North Charles Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21210 27-11

D. STREET ADDRESS (If rural, give location): 4508 North Charles Street

5. SEX: M

6. RACE: W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: Aug. 15, 1872

9. AGE (In years last birthday): 94

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired American Can Co,

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George S. Throop

14. MOTHER'S MAIDEN NAME: Catherine Fuhrer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-01-5683

17. INFORMANT: DR. Kathryn L. Schultz

ADDRESS: 2023 Cedar Circle Drive 21228

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Bronchopneumonia RLL	3 days
DUE TO (B)	Emphysema, pulmonary	20 yrs
DUE TO (C)	Arteriosclerosis, generalized	40 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Benign Prostatic Hypertrophy	10 yrs

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: None

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Aug 1947 to 21 Feb 1967, that (I) (~~we~~) last saw the deceased alive on 18 Feb 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Conrad Acton M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 21 Feb 67

23C. PHYSICIAN'S NAME (Type): Conrad Acton M.D.

23D. ADDRESS: 1208 Saint Paul Street Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Greenmount Crematory

24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Taylor

25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC.

ADDRESS: BALTIMORE, MARYLAND 21213

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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G-650

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1800 Registered No. 67 1800

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Catherine Green

2. DATE AND HOUR PRONOUNCED DEAD: 2/20/67 | 7:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1312 Walter Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21212 27-38
D. STREET ADDRESS (If rural, give location): 1312 Walter Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	white	widowed	June.12.1880	86				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md.	USA

13. FATHER'S NAME: John Long

14. MOTHER'S MAIDEN NAME: Elizabeth Wise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	Mrs. Lillian Helbig	1312 Walter Ave. Baltimore Md. 21212

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 1B. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/21/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Feb.23.1967	Mt. Carmel Cemetery	Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Farley, M.D.	HENRY SANDER & SONS. INC.	Baltimore Md.

VS 151-REV. 1/1/65

1967000 1805

R.2001

BIRTH NO. 67 1801

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1801

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Malcolm M. Rice

2. DATE AND HOUR OF DEATH: 2-20-67 11:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 1703

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore,

D. STREET ADDRESS (If rural, give location): 719 W. Lanvale Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 5-3-1885

9. AGE (In years last birthday): 82 yrs.

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Rice

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-03-4623

17. INFORMANT: Mrs. Ethel Rice - Wife ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 332X 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — 7 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus — 4 yrs

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from February 14, 1967 to February 20, 1967, that (I) (~~we~~) last saw the deceased alive on February 20, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: James D. Carr M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2-20-67

23C. PHYSICIAN'S NAME (Type): James D. Carr M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-23-67

24C. NAME of CEMETERY or CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Tarbert M.D.

25C. FUNERAL DIRECTOR: Charles R. Law ADDRESS: 802 Madison Ave.

VS 150-REV. 1/1/65

1967 0 0 1 8 0 6

W-6201

BIRTH NO. 67 1802

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1802

1. NAME OF DECEASED (Type or Print): WRIGHT MARY

2. DATE AND HOUR OF DEATH: 2/21/67 5:30 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-13

D. STREET ADDRESS (If rural, give location): 3521 VIRGINIA AVE.

5. SEX: F

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 7/5/84

9. AGE (In years last birthday): 82

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): USA - South Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ELI WHITE

14. MOTHER'S MAIDEN NAME: SARAH ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: HARRY M. WALEN ADDRESS: SINAI HOSP

MEDICAL CERTIFICATION

18. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) ASCVD — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): —

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/20/67 19 to 2/21/67 19, that (I) (we) last saw the deceased alive on 2/21/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harry M. Walen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): HARRY M. WALEN M.D.

23D. ADDRESS: SINAI HOSP

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-25-67

24C. NAME of CEMETERY or CREMATORY: Green Pone Methodist

24D. LOCATION (City, town, or county) (State): Clover, S. C.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Wm. Martin ADDRESS: N. York St., Gastonia, N. C.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G. 6501

BIRTH NO. 67 1803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1803

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALFRED GREEN

2. DATE AND HOUR OF DEATH: 2-21-67 1:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 15-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 2101 CLIFTON AVE

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 9-4-85

9. AGE (In years last birthday): 81

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Magothy Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Jennie Robertson ADDRESS: 2101 Clifton Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 293 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SEVERE ANEMIA

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-20 19 67 to 2-21 19 67, that (I) (we) last saw the deceased alive on 2-21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lucas C. Vidhyaphum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-21-67

23C. PHYSICIAN'S NAME (Type): LUCAS C. VIDHYAPHUM M.D.

23D. ADDRESS: Lutheran Hospital of Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/24/67

24C. NAME of CEMETERY or CREMATORY: Magothy Cemetry

24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Tulkyna

25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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F 432

BIRTH NO. 67 1804

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1804

1. NAME OF DECEASED (Type or Print): Sophia Fields

2. DATE AND HOUR PRONOUNCED DEAD: 2/21/67 8:13 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 212 N. Stricker St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1902

D. STREET ADDRESS (If rural, give location): 212 N. Stricker St.

5. SEX: female

6. RACE: colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12/25/99

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Fields

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Lillian Smith ADDRESS:

MEDICAL CERTIFICATION

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary emphysema and purulent bronchitis

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 2/21/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/25/67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry

23D. LOCATION (City, town, or county) (State): A A County Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

1 9 6 7 0 0 1 8 0 9

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S-536

BIRTH NO. 67 1805

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1805

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Carl Sanders

2. DATE AND HOUR PRONOUNCED DEAD: 2/19/67 7:10 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1311 N. Patterson Pk. Ave.

8-04

5. SEX: male
6. RACE: colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 3/11/23
9. AGE (In years last birthday): 42
If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): S Carolina
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Rome Sanders
14. MOTHER'S MAIDEN NAME: Malinda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Daisy Bullock
ADDRESS: 1311 Patterson Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E981X

(A) Necrotizing peritonitis following gunshot wound of abdomen
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1127 Whatcoat St. 16-02

21D. TIME OF INJURY (APPROX.): (Month) 2 (Day) 11 (Year) 67 (Hour) 2:45 p.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? shot in abdomen

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 2/19/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/25/67
23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
23D. LOCATION (City, town, or county) (State): A A County Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
24B. NAME OF REGISTRAR: Robert E. Gallagher
24C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

N879.4 1 9 6 7 0 0 0 1 8 1 0

P. 6251

BIRTH NO. 67 1806

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1806

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mildred A. Perkins

2. DATE AND HOUR OF DEATH: Feb. 22, 1967 | 12:45P M.

CERTIFICATE AMENDED 3-1-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — TITLE NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3919 Frankford Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 27-34
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3919 Frankford Ave.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2-12-67 1910
9. AGE (In years last birthday): 57
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Peter Gessner
14. MOTHER'S MAIDEN NAME: Ella McCaffery
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edison M. Perkins — ADDRESS: Above

MEDICAL CERTIFICATION

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Hemorrhage — 3 Years
DUE TO
(B) Arterial Hypertension — 5 Years
DUE TO
(C) (Second stroke 11-28-66)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 11-29-66 19 to 2-22-67 19, that (I) (~~we~~) last saw the deceased alive on 1-21-67 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C. W. Peake M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-23-67
23C. PHYSICIAN'S NAME (Type): C. W. Peake M.D.
23D. ADDRESS: 4508 Harford Rd.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-25-67
24C. NAME of CEMETERY or CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. — ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

B 0 1 8 1 1

Q-50

Released by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1807

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1807

1. NAME OF DECEASED (Type or Print): Quinn, Lawrence J.

2. DATE AND HOUR OF DEATH: 2/22/67 11:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hosp. 35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 104
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2227 Eastern Ave.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 10-11-1906
9. AGE (In years last birthday): 60
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMAN
10B. KIND OF BUSINESS OR INDUSTRY: CITY HARBOR BOARD
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANCIS L. Quinn
14. MOTHER'S MAIDEN NAME: LOUISE SEIFERT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-12-5773
17. INFORMANT: MRS. ELIZABETH H. GLAVIN
ADDRESS: 913 Reverdy Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 421.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

(B) Aortic Stenosis & Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Pulm. Emphysema

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/22/ 1967 to 2/22 1967, that (I) (we) last saw the deceased alive on 2/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/22/67
23C. PHYSICIAN'S NAME (Type): NEWITA SUAREZ M.D.
23D. ADDRESS: Church Home & Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/25/1967
24C. NAME of CEMETERY or CREMATORY: St. Matthew's
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Foley
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

0 1 8 1 2

VS 150-REV. 1/1/65

1

B-623

67 1808

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1808

1. NAME OF DECEASED (Type or Print): JOHN W. BERSTERMAN

2. DATE AND HOUR PRONOUNCED DEAD: February 20, 1967 | 12:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: Maryland General Hospital (DOA)

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 401

D. STREET ADDRESS (If rural, give location): 314 N. Park Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Feb. 22, 1889

9. AGE (In years last birthday): 77 X8

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Bersterman

14. MOTHER'S MAIDEN NAME: Catherine Remmel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-05-1669

17. INFORMANT: Mrs. Mary E. Bersterman

ADDRESS: 314 N. Park Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 4221

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Russell S. Fisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

DATE SIGNED: February 20, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2-23-67

23C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

24B. NAME OF REGISTRAR:

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc.

ADDRESS: 1217 St. Paul St.

VS 151-REV. 1/1/65

67 0 0 1 8 1 3

1
M-520

BIRTH NO. 67 1809

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1809

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Robert F. Minke	2. DATE AND HOUR PRONOUNCED DEAD 2/21/67 11:30 a. m.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2111 Maryland Ave.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-06 D. STREET ADDRESS (If rural, give location): 2111 Maryland Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
male	white	single	6-13-1924	42 ~~88~~	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	Ship yards	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Minke	Mary Hipsman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II 1940- 45	214-15-9631	Eugene Minke	2323 Md. Ave., Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

581.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty alteration of liver

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ xx and that on this basis, death in my opinion resulted from: Natural causes ☒ x Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
~~ASSIST~~ANT MEDICAL EXAMINER ☒ x
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 2/21/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2-27-67	Baltimore National	Catonsville, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	R. E. Farber M.D.	Wm. Cook-Brooks, Inc.	1217 St. Paul St., Balto., Md. 21202

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 8 1 4

T-413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1810 Registered No. 67 1810

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TALBOT, DR. SAMUEL

2. DATE AND HOUR OF DEATH: 2/20/67 1 45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 8218 Bellona Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 4/19/03

9. AGE (In years last birthday): 63

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Biophysist

10B. KIND OF BUSINESS OR INDUSTRY: Hopkins Med. School

11. BIRTHPLACE (State or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: xRxxxRx Winthrop Talbot

14. MOTHER'S MAIDEN NAME: Edith Armstrong

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Records- Johns Hopkins Hosp ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 181.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of bladder,

DUE TO

(B) metastatic

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/11/67 19 to 2/20/67 19, that (I) (we) last saw the deceased alive on 2/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R J Owellen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): R. J. Owellen M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Greemmount Crematory

24D. LOCATION (City, town, or county) (State): Baltimore City, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Alan E. Fabry MA

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, Inc. BROOKS, TOWSON, Md ADDRESS 1010 York Rd.

VS 150-REV. 1/1/65

1 9 6 7 0 0 1 8 1 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1811 Registered No. 67 1811

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DiBenedetto, John D.

2. DATE AND HOUR OF DEATH: February 20, 1967 | 1:00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2922 Limond Place

9-04

27

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12/23/1900

9. AGE (In years last birthday): 66

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): operator

10B. KIND OF BUSINESS OR INDUSTRY: switchboard

11. BIRTHPLACE (State or foreign country): Thomas W. Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rocco DiBenedetto

14. MOTHER'S MAIDEN NAME: Gaeting DiBacco

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): 10/27/42 - 4/9/43

16. SOCIAL SECURITY NO.: 220-03-9205

17. INFORMANT: 3900 Loch Raven Blvd

ADDRESS: VA Hospital Records, Baltimore, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

420.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Pulmonary mycotic disease — 1 year

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from September 8th 19 66 to February 20th 19 67, that (I) (we) last saw the deceased alive on February 20th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert R. Kent M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): ROBERT R. KENT M.D.

23D. ADDRESS: VAH Baltimore, Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/24/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore City, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Wm. Cook Brooks Inc.

ADDRESS: 1217 St. Paul St.

VS 150-REV. 1/1/65

67 001816

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1812 Registered No. 67 1812

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BESSIE MAE GARDELLA

2. DATE AND HOUR OF DEATH: FEBRUARY 22, 1967 10:50 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 1901 SUNDERRY ROAD

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 6/9/01

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: (–)

11. BIRTHPLACE (State or foreign country): GEORGIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES PAUL

14. MOTHER'S MAIDEN NAME: MARY JANE CARVER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 577102477

17. INFORMANT: CHART

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cor. Pulmonale

DUE TO

(B) Severe Emphysema.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from ~~10/31~~ 10/31/19 67 to 2/22 19 67, that ~~(I)~~ (we) last saw the deceased alive on 2/22 19 67 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Ferdinand C. Rodriguez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): FERDINAND C. RODRIGUEZ M.D.

23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): ~~2-25-6~~

24B. DATE: 2-25-67

24C. NAME of CEMETERY or CREMATORY: Maplewood Cemetery

24D. LOCATION (City, town, or county) (State): Orange Co, Fordonville VA.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: R. Gale E. Fagley M.D.

26C. FUNERAL DIRECTOR: W. Cook-Brooks, N.C.

ADDRESS: BALTO, MD 21202

VS 150-REV. 1/1/65

0 0 1 8 1 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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K-620

BIRTH NO. 67 1813

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1813

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret Kraus

2. DATE AND HOUR PRONOUNCED DEAD: 2/20/67 5:16 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 4519 Mainfield Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 27-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 4519 Mainfield Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: August 26, 1904.

9. AGE (In years last birthday): 62

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Neuberger

14. MOTHER'S MAIDEN NAME: Marie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Elias G. Kraus

ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic and hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/21/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/24/67.

23C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

24B. NAME OF REGISTRAR: R. E. Fischman

24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: Balto. Md. 21214

VS 151-REV. 1/1/65

1 9 6 7 0 0 1 8 1 8

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C-523

BIRTH NO. 67 1814

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1814

1. NAME OF DECEASED (Type or Print): Donald G. Constable

2. DATE AND HOUR PRONOUNCED DEAD: 2/21/67 9:15 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 3608 Evergreen Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21206

D. STREET ADDRESS (If rural, give location): 3608 Evergreen Ave.

22-44

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	Married	January 31, 1913.	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Baking Company	Maryland	USA

13. FATHER'S NAME: Charles B. Constable

14. MOTHER'S MAIDEN NAME: Lillian ~~X~~ Gibson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-07-0812

17. INFORMANT: Mrs. Emma A. Constable

ADDRESS: (Same)

MEDICAL CERTIFICATION

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/21/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/24/67.	Parkwood Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967		Leonard J. Ruck, Inc.	Balto. Md. 21214

VS 151-REV. 11/65

1967000181 2

1
E-415

BIRTH NO. 67 1815

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1815

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Samuel V. Elbon

2. DATE AND HOUR PRONOUNCED DEAD: 2/18/67 12:53 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 23 E. 21st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 23 E. 21st St.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: January 12, 1918.
9. AGE (In years last birthday): 49
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clarence R. Elbon
14. MOTHER'S MAIDEN NAME: Amelia T. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W W 2
16. SOCIAL SECURITY NO.: 232-22-4556
17. INFORMANT: Mr. Fred Elbon, ADDRESS: Bridgeport, West Virginia.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 581.0

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty alteration of liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): partial
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy Partial ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/19/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/24/67.
23C. NAME of CEMETERY or CREMATORY: Tacy Cemetery
23D. LOCATION (City, town, or county) (State): Huttonsville, West Virginia.

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
24B. NAME OF REGISTRAR: Robert E. Fisher M.D.
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 8 2 0

C-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1816 Registered No. 67 1816

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Patsy Conte

2. DATE AND HOUR OF DEATH: Feb. 21, 1967 6 05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 1243 Woodbourne Ave.

44

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 5-5-1908
9. AGE (In years last birthday): 58
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Conte
14. MOTHER'S MAIDEN NAME: Eleanor Pulcino

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): 1926--1927
16. SOCIAL SECURITY NO.: 212-14-9941
17. INFORMANT: Mazie Conte ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarct

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/25 1966 to 1/24 1967, that (I) (we) last saw the deceased alive on 1/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles M. Classen Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/22/67
23C. PHYSICIAN'S NAME (Type): Charles Classen, Jr. M.D.
23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): burial
24B. DATE: 2/25/67.
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Gaskins M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc Baltimore, Md. ADDRESS:

VS 150-REV. 1/1/65

1 9 6 7 0 5 0 1 8 2 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-656

BIRTH NO. 67 1817

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1817

1. NAME OF DECEASED (Type or Print): BERNARD, MORRIS J.

2. DATE AND HOUR PRONOUNCED DEAD: February 21, 1967 11:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-02

D. STREET ADDRESS (If rural, give location): 2103 Callow Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Colored	Single	Dec. 8, 1927	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stevedore		Balto., Md.	

13. FATHER'S NAME: Luke Bernard

14. MOTHER'S MAIDEN NAME: Ruth Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Korean	220-20-6491	Minnie Willaims	2718 Edmondson Ave.

MEDICAL CERTIFICATION

1B. 581.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Congestive Heart Failure

DUE TO

(B) Cirrhosis of Liver (by history)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE R Breitenecker M.D.

EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.

DATE SIGNED 2/22/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/27/67	Balto. National Cem.	Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Farley M.D.	Wm C March	928 E. North Ave.

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 8 2 2

J-5210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1818 Registered No. 67 1818

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JONES JOHNNIE

2. DATE AND HOUR OF DEATH: 2/19/67. 5.30 AM A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-38

D. STREET ADDRESS (If rural, give location): 3013 CHELSEA TERR

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 7-13-14

9. AGE (In years last birthday): 52

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N. CAROLINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: WILLIAM ADDRESS: UNKNOWN

MEDICAL CERTIFICATION

18. 307X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) U PNEMONIA

DUE TO

(B) CHRONC ALCOHOLISM WITH

DUE TO

(C) DELERIUM TREMENS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (We) (this hospital) attended the deceased from 2-17-1967 to 2-19-1967, that (I) (We) last saw the deceased alive on 2-19-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Biswanath Pillai M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/19/67

23C. PHYSICIAN'S NAME (Type): V. BISWANATH PILLAI M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Ce

24D. LOCATION (City, town, or county) (State): Anne Arundel Cty. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR: WM. MARCH ADDRESS: 928 E. North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1967 000 1823

1

H-630

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1819 Registered No. 67 1819

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROLAND HARDY

2. DATE AND HOUR PRONOUNCED DEAD: February 22, 1967 1:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 500 N. Stricker Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 500 N. Stricker Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: Feb 4 1920
9. AGE (In years last birthday): 47
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rubber Plant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Hardy
14. MOTHER'S MAIDEN NAME: Helen Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Shelmer Brooks ADDRESS: 1610 Lanvale St

MEDICAL CERTIFICATION

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 331X

CAUSE OF DEATH: Spontanous intracerebral hemorrhage (cerebellum)

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werener U. Spitz M.D.

EXAMINER'S NAME (Type): Werener U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: February 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-25-67
23C. NAME of CEMETERY or CREMATORY: Arbutus Cem
23D. LOCATION (City, town, or county) (State): Lansdowne Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
24B. NAME OF REGISTRAR: R. Jos. E. Fahey
24C. FUNERAL DIRECTOR: Floyd Wilson
ADDRESS: 1030 Brantly Ave

VS 151-REV. 1/1/65

1967 0001824

S-455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1820 Registered No. 67 1820

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John Sellman

2. DATE AND HOUR OF DEATH: 2/20/67 7:10 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gould Convalescent Home Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-08
D. STREET ADDRESS (If rural, give location): 231 S. Highland Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7/21/1900
9. AGE (In years last birthday): 66
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): fireman
10B. KIND OF BUSINESS OR INDUSTRY: Fire Dept.
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unk.
14. MOTHER'S MAIDEN NAME: unk.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 219-38-2849
17. INFORMANT: Mrs. Rossini 6514 79th St. ADDRESS Middle Village N.Y.

MEDICAL CERTIFICATION

1B. 181.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of Urinary Bladder

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan. 1966 to 2/20 1967, that (I) (~~we~~) last saw the deceased alive on 2/19 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Joseph R. Liberto M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/22/67
23C. PHYSICIAN'S NAME (Type): JOSEPH R. LIBERTO M.D.
23D. ADDRESS: 3508 Bank St. - Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/23/67
24C. NAME of CEMETERY or CREMATORY: Oaklawn Cem
24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Joseph N. Zanneck ADDRESS 763 S. Conklin St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

B-625

BIRTH NO. 67 1821

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1821

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BRACONE, NICHOLAS MARIO (Nickolas)

2. DATE AND HOUR OF DEATH: FEBRUARY 17, 1967 | 3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 25-04

D. STREET ADDRESS (If rural, give location): 3822 - 6TH STREET

5. SEX: MALE

6. RACE: CAUCASIAN

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 2-29-88

9. AGE (In years last birthday): 78

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WAITER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ITALY

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: NICKOLAS BRACONE

14. MOTHER'S MAIDEN NAME: MARY DEGIROGIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): 4/29/18-12/19/18

16. SOCIAL SECURITY NO.: 213-03-99-36

17. INFORMANT: VA HOSPITAL RECORDS ADDRESS: 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162.1

(A) BRONCHOGENIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

1. GENERALIZED ARTERIOSCLEROSIS

2. CHRONIC PYELONEPHRITIS

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 22 1965 to FEBRUARY 17 1967, that (I) (we) last saw the deceased alive on FEBRUARY 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David Marine M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/17/67

23C. PHYSICIAN'S NAME (Type): DAVID N. MARINE M.D.

23D. ADDRESS: VA HOSPITAL BALTIMORE, MARYLAND

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-21-1967

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Fankenmeier

25C. FUNERAL DIRECTOR: George J. Gonce

ADDRESS: 4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

0 0 1 8 2 6

1

S-360

BIRTH NO. 67 1822

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1822

CERTIFICATE AMENDED

43

1. NAME OF DECEASED (Type or Print): IRA L. SOWDER	2. DATE AND HOUR PRONOUNCED DEAD: February 20, 1967 12:40 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-05 D. STREET ADDRESS (If rural, give location): 3700 Pennington Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
Male	White	Divorced	Aug. --, 1910	56	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Chemical	Unknown	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ira Jackson Sowder	Julia ???

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
??		--	Mrs. Lem Friedman	3700 Pennington Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. E910.6

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fracture of right tibia

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fatty metamorphosis of liver

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	tavern	Walk-in cooler at Friedman's Tavern 25-05

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
~~2-19-67 between 7:00 & 7:30 P.M.~~ 2-12-67 About 6 P.M.	WHILE AT WORK [X] NOT WHILE AT WORK [ ]	Presumably dropped case of beer on foot.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE R S Fisher M.D.

EXAMINER'S NAME (Type) Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED February 20, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2-22-1967	Holy Cross Cemetery	Ritchie Hgwy., A.A.Co., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Fahrney	George J. Gonce	4001 Ritchie Hgwy., Baltimore

VS 151-REV. 1/1/65

N 23 1967 0001827

Letter from M.E!s office 3-29-67 M.H.

H-251

BIRTH NO. 67 1823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1823

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lou Fannie Hawkins

2. DATE AND HOUR OF DEATH: 2-15-1967 | 8:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 George Washington Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-02

D. STREET ADDRESS (If rural, give location): 107 N. Bentlow St.

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 1-1-1874

9. AGE (In years last birthday): 93

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 212-56-8891

17. INFORMANT: Chart # 725, 607 Penn Ave ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic H. Disease

DUE TO

(B) Secondary Anemia

DUE TO

(C) U.R.I. Malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-15th 1964 to 2-15th 1967, that (I) (we) last saw the deceased alive on 2-11th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. L. Weaver M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb. 15th 67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 1944 Druid Hill Ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/21/67

24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cemetery

24D. LOCATION (City, town, or county) (State): Glen Burnie Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Ralph E. Fahrney M.D.

25C. FUNERAL DIRECTOR: Levi P. Covell

ADDRESS: 1712 W. North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

N-400

BIRTH NO. 67 1824

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1824

1. NAME OF DECEASED (Type or Print): Annie E. Noel

2. DATE AND HOUR OF DEATH: February 21, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4000 Fairfax Road Baltimore, Maryland 21216

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-09

D. STREET ADDRESS (If rural, give location): 4000 Fairfax Road 16

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Sept. 6, 1876

9. AGE (In years last birthday): 90

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never worked

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Cook

14. MOTHER'S MAIDEN NAME: Betty Puder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Jewel Noel

ADDRESS: same address as above

MEDICAL CERTIFICATION

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBROVASCULAR ACCIDENT — 10 minutes

DUE TO

(B) GENERALIZED CEREBRO-VASCULAR ARTERIOSCLEROTIC DISEASE — many years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION fast.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from JAN 1967 to 2/21 1967, that (I) ~~(we)~~ last saw the deceased alive on 2/21/67 at 9:45 AM 19 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stuart A. Perkal M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): STUART A. PERKAL M.D.

23D. ADDRESS: 2948 HARRISON BLVD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Lankford M.D.

25C. FUNERAL DIRECTOR: Wm. F. Tilmont & Sons

ADDRESS: Balto. & Bl. Laws. North

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-2 60

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1825 Registered No. 67 1825

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Amelia Emily Wigger

2. DATE AND HOUR OF DEATH: 20 Feb 67 5:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Montebello State Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1805
D. STREET ADDRESS (If rural, give location): 2010 St. Paul Street

5. SEX: F
6. RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~Married~~ Widowed
8. DATE OF BIRTH: 8-11-86
9. AGE (In years last birthday): 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Charleston S.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Hentze
14. MOTHER'S MAIDEN NAME: Amelia Ludwig

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-05-9128D
17. INFORMANT: Hospital chart
ADDRESS:

MEDICAL CERTIFICATION

CERTIFICATION APPROVED BY: [illegible] M.D. CHIEF OR ASST. MEDICAL EXAMINER

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Prob. Myocardial infarction — Immediate
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture Right Hip

19A. DATE OF OPERATION: 12-24-66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fractured R. Hip.
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): Neither
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2010 St. Paul Street
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12-23-66
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒
21F. HOW DID INJURY OCCUR? Fall in her home.

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1-24 1967 to 2-20 1967, that ~~(I)~~ (we) last saw the deceased alive on 2-20 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ ~~(We)~~ (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Charles R. Lockert M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 20 Feb 67
23C. PHYSICIAN'S NAME (Type): Charles R. Lockert M.D.
23D. ADDRESS: Montebello State Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/23/1967
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 23 1967
25B. NAME OF REGISTRAR: Robert E. Fabiano
25C. FUNERAL DIRECTOR: Wm. J. Tilmes & Sons
ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65 N 820,0 8 5 0

R-351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1826 Registered No. 67 1826

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Pearl E. Redman

2. DATE AND HOUR OF DEATH: 2/20/67 3 45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital 44 Baltimore 18 Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Maryland 21212

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-12

D. STREET ADDRESS (If rural, give location): 212 St. Dunstans Rd

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: 12-15-95

9. AGE (In years last birthday): 71

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John C. Redman

14. MOTHER'S MAIDEN NAME: Elizabeth N. Trexler

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Florence R. Crawford ADDRESS: 212 St. Dunstans Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1 V-260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio vascular disease

DUE TO

(B) Acute Congestive heart failure

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2/20 1967 to 2/20 1967, that (I) (~~we~~) last saw the deceased alive on 2/20 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Alfred G. Ossman Jr M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): Alfred G. Ossman Jr M.D.

23D. ADDRESS: 1010 St Paul St Balto 2 Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-24-1967

24C. NAME of CEMETERY or CREMATORY: Greenmount

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave.,

VS 150-REV. 1/1/65

0 1 8 3 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-515

BIRTH NO. 67 1827

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1827

1. NAME OF DECEASED (Type or Print): Ethel I. Donovan

2. DATE AND HOUR OF DEATH: FEB. 19, 1967. 2:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLES GENERAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY: 4-09

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE #21224.

D. STREET ADDRESS (If rural, give location): 3512 O'DONNELL ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	JUNE 5, 1903	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	GLENN L. MARTIN Co.	FROSTBURG, MD.	U.S.A.

13. FATHER'S NAME: ROBERT McDONALD

14. MOTHER'S MAIDEN NAME: TINA MILLER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-22-6449

17. INFORMANT: GRANVILLE J. DONOVAN, ADDRESS: SAME.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO ARTERIOSCLEROTIC C.V. DIS. — 1 yr.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2/18/67		YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/14 1953 to 2/19 1967, that (I) (we) last saw the deceased alive on 2/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Benjamin Highstein M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): BENJAMIN HIGHSTEIN M.D.

23D. ADDRESS: 121 S. HIGHLAND AVE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	2-22-67	OAK LAWN CEM.	7225 EASTERN BLVD, BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Farley, M.D.	Charles A. Geiler	901 S. CONKLING ST. BALTO., 21224, MD.

VS 150-REV. 1/1/65

1 9 6 7 0 0 0 1 8 3 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-6-6-0

BIRTH NO. 67 1828

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1828

1. NAME OF DECEASED (Type or Print): ANNA GRIEB

2. DATE AND HOUR OF DEATH: February 18, 1967 | 11:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(If not in hospital or institution, give street address or location): 814 S. Dean St. Balto., 21224, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-09

D. STREET ADDRESS (If rural, give location): 814 S. Dean St. # 21224,

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	Aug. 12, 1891	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	At Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: August Patzwall

14. MOTHER'S MAIDEN NAME: Kunigunda Wachter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	------	None	Frank H. Grieb, Sr.	Same.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardio vascular disease —

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 8 1965 to 2/18 1967, that (I) (~~we~~) last saw the deceased alive on 2/15 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Joseph R. Liberto M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/20/67

23C. PHYSICIAN'S NAME (Type): JOSEPH R. LIBERTO M.D.

23D. ADDRESS: 3508 Bank St. Balto., 21224, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-22-67.	Sacred Heart Cemetery	7401 German Hill Rd., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 23 1967	Robert E. Fasbender	Charles S. Geiler	901 S. Conkling St. Balto., 24, Md.

VS 150-REV. 1/1/65

1967 000 1863

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

[redacted]TH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1829 — 22557 — Registered No. 67 1829

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MC Coy, SHAWN M.

2. DATE AND HOUR OF DEATH: 2/21/67 5 00 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSP. 37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE — B. COUNTY: 914 Thompson Blvd.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Bpmo. Md. Balto. Co.

D. STREET ADDRESS (If rural, give location): 2121 53-00

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 10/14/66

9. AGE (In years last birthday): 13 yr 4 m

If Under 1 Yr. Months Days — If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child.

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gerald M. McCoy Jr

14. MOTHER'S MAIDEN NAME: Margaret Johnston McCoy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Gerald McCoy Jr — ADDRESS: above

MEDICAL CERTIFICATION

18. 752X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardio-Respir Failure

DUE TO

(B) Brain damage 2° to hydrocephalus since birth

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED — While At Work ☐ — Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 2/21/67 19 67 to 2/21/67 19 67, that ~~I~~ (we) last saw the deceased alive on 2/21/67 19 67 and that In ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Jos. M. France M.D. — Attending Phys. ☐ — Med. Director ☐ — Staff Phys. ☑

23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): JOSEPH M. FRANCE M.D.

23D. ADDRESS: Mercy Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: Sacred Heart

24D. LOCATION (City, town, or county) (State): Balto Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 23 1967

25B. NAME OF REGISTRAR: R. L. E. Falkenhan

25C. FUNERAL DIRECTOR: J. G. Connelly Sons

ADDRESS: 300 Mura

VS 150-REV. 1/1/65

[redacted] 0 0 0 1 8 3 4

A-552

BIRTH NO. 67 1830

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1830

1. NAME OF DECEASED (Type or Print): Sister Marie Annunciata

2. DATE AND HOUR OF DEATH: Feb. 20th, 1967 | 6:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Valley Road B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Brooklandville, Maryland

D. STREET ADDRESS (If rural, give location): 53-00

5. SEX: F

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): never married

8. DATE OF BIRTH: 2-10-98

9. AGE (In years last birthday): 69 yrs

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): religious

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Castaldi

14. MOTHER'S MAIDEN NAME: Marie D'Ambra

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) intractable congestive heart failure — approx 24 hrs.

DUE TO

(B) probable myocardial infarction — approx 24 hrs

DUE TO

(C) atherosclerotic cardiovasc. disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from February 19 19 67 to February 20 19 67, that (I) ~~(we)~~ last saw the deceased alive on February 20 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Raymond E. Knowles, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-20-67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE

24C. NAME of CEMETERY or CREMATORY: CONVENT CEMETERY

24D. LOCATION (City, town, or county) (State): ILCHESTER, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Lashley M.D.

25C. FUNERAL DIRECTOR: Farley-Cavanaugh

ADDRESS: 6601 Frederick Rd.

VS 150-REV. 1/1/65

1 9 6 7 0 0 0 1 8 3 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-453

BIRTH NO. 67 1831

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1831

1. NAME OF DECEASED (Type or Print): BRETHED D. WAYLAND

2. DATE AND HOUR OF DEATH: 15 February 1967 | 11:45 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Penitentiary Hospital 954 Forrest Street

92

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balt. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore City 53-00

D. STREET ADDRESS (If rural, give location): 4 North Point Terrace

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	8 March 1903	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Manufacturing	Johnstown, Pennsylvania	U.S.A.

13. FATHER'S NAME: Irwin Wayland

14. MOTHER'S MAIDEN NAME: Emma Fisher

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): 1948-52

16. SOCIAL SECURITY NO.

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. ICD 193.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma of Brain (Metastatic)

DUE TO

(B) Primary Malignancy not determined

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 05 Jan 1967

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Tumors, left parietal area

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 16 November 1966 to 15 February 1967, that (I) (we) last saw the deceased alive on 15 February 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Henry W.D. Holljes M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 15 February 1967

23C. PHYSICIAN'S NAME (Type): Henry W.D. Holljes M.D.

23D. ADDRESS: 954 Forrest Street, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 2-27-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Fallon

25C. FUNERAL DIRECTOR:

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
S-530

BIRTH NO. 67 1832

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1832

1. NAME OF DECEASED (Type or Print): WILLIAM SMITH

2. DATE AND HOUR PRONOUNCED DEAD: 2-10-67 7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 106 N. WOLFE STREET - (Amb. Crew #10)
00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-04
D. STREET ADDRESS (If rural, give location): 106 N. Wolfe Street 21205

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): 57
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 4200

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Partial

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. Partial
I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes XX Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.
EXAMINER'S NAME (Type) CHARLES S. SPRINGATE, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 2-10-67

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

23A. BURIAL CREMATION, REMOVAL (Specify):
23B. DATE: 2-21-67
23C. NAME of CEMETERY or CREMATORY:
23D. LOCATION (City, town, or county) (State):

24A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
24B. NAME OF REGISTRAR: Robert E. Gainey, M.D.
24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 8 3 2

48-38-84 TN T-624 67 1833

BIRTH NO. 67 1833

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1833

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Albert Troxell

2. DATE AND HOUR OF DEATH: 2/9/67 10:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

1802

D. STREET ADDRESS (If rural, give location): 1000 W. BALTIMORE ST. 21223

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: 12-25-81

9. AGE (In years last birthday): 85

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLIE TROXELL

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: BCH: RECORDS ADDRESS: 4940 EASTERN AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	sepsis	2 weeks
DUE TO (B)	urinary tract infection	6 weeks
DUE TO (C)	esophageal Ca	6 months

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/1/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: atonic bladder

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/29 1966 to 2/9 1967, that (I) (we) last saw ~~the deceased~~ alive on 2/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Bruce M. Dow M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/9/67

23C. PHYSICIAN'S NAME (Type): BRUCE M. DOW M.D.

23D. ADDRESS: BCH BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 2-21-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMY ... UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Farbaugh M.D.

25C. FUNERAL DIRECTOR:

ADDRESS:

VS 150-REV. 1/1/65

19670001838

1
C-140

BIRTH NO. 67 1834

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1834

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIE CAPLE

2. DATE AND HOUR PRONOUNCED DEAD: January 31, 1967 9:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 102 N. Carlton Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): 51
If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

✓ 1B. 340.3 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Purulent meningitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1-13-67

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

23A. BURIAL CREMATION, REMOVAL (Specify):
23B. DATE: 2-2-67
23C. NAME of CEMETERY or CREMATORY:
23D. LOCATION (City, town, or county) (State):

24A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 151-REV. 1/1/65

1967 0001839

47-76-63 P-1 36
FR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1835 Registered No. 67 1835

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ezra Francis PRATHER

2. DATE AND HOUR OF DEATH: 12 FEBRUARY, 1967 | 9 00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2717 Faith Avenue 21224

109 Fait

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 1-3-1898
9. AGE (In years last birthday): 69
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 220-30-1507A
17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue 21224 — ADDRESS:

CERTIFICATION APPROVED BY: Robert L. Sm M.D. CHIEF OR ASST. MEDICAL EXAMINER

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — 10 Days
DUE TO: Klebsiella aerobacter
(B) ~~Cerebral trauma~~ — 8 months
DUE TO:
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cranio Cerebral Injury

19A. DATE OF OPERATION: 6-22-66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2717 FAITH AVE 1-04
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.): 6-28-66
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑
21F. HOW DID INJURY OCCUR? FELL down three steps

22. I certify that (I) (this hospital) attended the deceased from 22 SEPTEMBER, 1966 to 12 FEBRUARY, 1967, that (I) (we) last saw the deceased alive on 12 FEBRUARY, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel D. Foote M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12 FEBRUARY, 1967
23C. PHYSICIAN'S NAME (Type): Dr. Daniel D. Foote M.D.
23D. ADDRESS: Baltimore City Hospitals, 4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 2-23-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or County) (State):

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Robert E. Tallman
25C. FUNERAL DIRECTOR:
25D. ADDRESS:

AMERICAN ... JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE

VS 150-REV. 1/1/65 V 856 129 67 0001810

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

S-120

67 1836

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1836

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH E. SVECK

2. DATE AND HOUR PRONOUNCED DEAD: February 12, 1967 11:16 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital (DOA)

33/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-04

D. STREET ADDRESS (If rural, give location): 1048 N. Broadway

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH:

9. AGE (In years last birthday): 84

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: February 13, 1967

23A. BURIAL CREMATION, REMOVAL (Specify):

23B. DATE: 2-20-67

23C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND

23D. LOCATION (City, town, or county) (State):

24A. DATE RECORDED BY HEALTH DEPT.: FEB 22 1967

24B. NAME OF REGISTRAR:

24C. FUNERAL DIRECTOR: JOHNS HOPKINS MEDICAL SCHOOL

ADDRESS: MORTUARY SERVICE - BCHD

VS 151-REV. 1/1/65

1967 0001841

L-620

BIRTH NO. 67 03337 67 1837

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1837 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY BOY LUERS

2. DATE AND HOUR OF DEATH: FEBRUARY 17, 1967 6 40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-01
D. STREET ADDRESS (If rural, give location): 4213 LA SALLE AVE 21206

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 2/17/67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 10 Min.: 45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PAUL M.
14. MOTHER'S MAIDEN NAME: SARAH DIDIO

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: J. ALMAND, M.D. ADDRESS: UNION MEM. HOSP

MEDICAL CERTIFICATION

18. 560.41
CAUSE OF DEATH — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

(A) ~~INADEQUATE CARE~~
DUE TO
(B) ~~MALFUNCTION LUNG~~ ~~CONGENITAL~~
DUE TO
(C) Congenital diaphragmatic hernia.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2/17 1967 to 2/17 1967, that (I) (~~we~~) last saw the deceased alive on 2/17 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Joseph M. Almand Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 17 February 1967
23C. PHYSICIAN'S NAME (Type): DR JOSEPH M ALMAND JR M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 2-20-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Robert E. Fallows
25C. FUNERAL DIRECTOR:
ADDRESS:

VS 150-REV. 1/1/65

1967 0 0 1 8 3 7

1

M-2 25

BIRTH NO. 67 1838

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1838

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN E. McGUCKIN

2. DATE AND HOUR PRONOUNCED DEAD: February 8, 1967 | 7:40 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 5 North Exeter Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-01

D. STREET ADDRESS (If rural, give location): 5 North Exeter Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH:

9. AGE (In years last birthday): 55

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Alcoholism

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Severe Ascites

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): ~~No~~ YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☑ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

DATE SIGNED: 2/9/67

23A. BURIAL CREMATION, REMOVAL (Specify):

23B. DATE: 2-15-67

23C. NAME of CEMETERY or CREMATORY:

23D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

24A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

24B. NAME OF REGISTRAR: Robert E. Lankford

24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BOB

ADDRESS:

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 8 4 3

M-460

BIRTH NO. 67 67 1839 67 1839

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1839 t

1. NAME OF DECEASED (Type or Print): Baby Girl Miller

2. DATE AND HOUR OF DEATH: 2-10-67 18:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 24 B

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21236

D. STREET ADDRESS (If rural, give location): 1042 Williams ST.

5. SEX: F

6. RACE: Wh.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Newborn

8. DATE OF BIRTH: 2-10-67

9. AGE (In years last birthday): N.B

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours 3½ | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Judy Miller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 762.15 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Immaturity

DUE TO

(B) Congenital Atelectasis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-10 1967 to 2-10 1967, that (I) (we) last saw the deceased alive on 2-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-13-67

23C. PHYSICIAN'S NAME (Type): GRACE P. AYUYAO M.D.

23D. ADDRESS: South Baltimore Gen Hospital

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 2-15-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

VS 150-REV. 1/1/65

1967 0 0 1 8 3 9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N 6201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1840 Registered No. 67 1840

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Owen L. Norris

2. DATE AND HOUR OF DEATH: 2-21-67 | 5:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

2912 Miles Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-07

D. STREET ADDRESS (If rural, give location): 2912 Miles Avenue

5. SEX: M

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Div

8. DATE OF BIRTH: August 23, 1902

9. AGE (In years last birthday): 63

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Owen Norris

14. MOTHER'S MAIDEN NAME: Fannie Calp

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edward Norris

ADDRESS: Rt. 1 Box 202A Millers, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Myocardial Infarction - Acute DUE TO

(B) Arteriosclerotic Cardiovascular Disease DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from July 1966 to February 21 1967, that (I) ~~(we) last~~ saw the deceased alive on 2-15 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We) (did)~~ (did not) view the body after death.

23A. SIGNATURE: Miriam R. Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-21-67

23C. PHYSICIAN'S NAME (Type): Miriam L. Cohen M.D.

23D. ADDRESS: Baltimore, Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-23-67

24C. NAME of CEMETERY or CREMATORY: Mt. Hope Cemetery

24D. LOCATION (City, town, or county): Middletown, Fred. Co (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Gladhill Company, Middletown, Maryland

ADDRESS:

VS 150-REV. 1/1/65

1 9 6 7 0 2 0 1 8 4 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

GG 48-51-39 K-400

BIRTH NO. 67 1841

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1841

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): THOMAS M KELLY

2. DATE AND HOUR OF DEATH: 2-10-67 | 9 20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore 21224, Maryland

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 7 East Center Street #21202

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Single	2-3-87	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 9

10B. KIND OF BUSINESS OR INDUSTRY: 9

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Kelly

14. MOTHER'S MAIDEN NAME: Jane Mooney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): 1 (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 046-14-7536A

17. INFORMANT: RECORDS: BCH 4940 Eastern Ave. #21224 — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 465 X 14-122 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolus (prob) — immediate

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart failure, Ca of Prostate

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1·16 1967 to 2·10 1967, that (I) ~~(we)~~ last saw the deceased alive on 2·10 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: James T. Corkins M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2·10·67

23C. PHYSICIAN'S NAME (Type): Dr. James T. Corkins M.D.

23D. ADDRESS: 4940 Eastern Avenue #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-23-67

24C. NAME of CEMETERY or CREMATORY: Sacred Heart Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Sahuma

25C. FUNERAL DIRECTOR: Walter Dabrowski — ADDRESS: 1005 Dundalk Ave

VS 150-REV. 1/1/65

1

M-000

BIRTH NO. 67 1842

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1842

1. NAME OF DECEASED (Type or Print): Massie ~~XXXXXX~~ MAYO

2. DATE AND HOUR PRONOUNCED DEAD: 2-20-67 6:55 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): MARYLAND GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02

D. STREET ADDRESS (If rural, give location): 859 Park Avenue

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Jan. 3, 1925	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Constuuction	Virginia	U.S.A.

13. FATHER'S NAME: John T. Mayo

14. MOTHER'S MAIDEN NAME: Sara W. Lowry - Waynesboro, Va

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW III	Unknown	Clyde Mayo	

MEDICAL CERTIFICATION

1B. 581.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty alteration of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2-21-67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/24/67	Lynhurst Meth. Ch. Cem.	Waynesboro, Va.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 24 1967	Robert E. Farkas M.D.	Walter Dabrowski	1005 Dundalk Av.

VS 151-REV. 1/1/65

1967000 1847

1
R-300

BIRTH NO. 67 1843

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

X Registered No. 67 1843

1. NAME OF DECEASED (Type or Print): J. Frank Rott

2. DATE AND HOUR PRONOUNCED DEAD: 2/20/67 10:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 Armco Dispensary
Edison Hwy. and Biddle St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balti Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 2706 North Point Rd.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 7/27/1911
9. AGE (In years last birthday): 55
If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Operator
10B. KIND OF BUSINESS OR INDUSTRY: Armco Steel
11. BIRTHPLACE (State or foreign country): Petersburg, Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Anton Rott
14. MOTHER'S MAIDEN NAME: Barbara Kratochvil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 228-14-1827
17. INFORMANT: Anna J. Rott (nee Cizler) wife, above
ADDRESS: above

MEDICAL CERTIFICATION

18. 416 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic heart disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/20/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/24/67
23C. NAME of CEMETERY or CREMATORY: Sacred Heart Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3331 Brehms Lane

VS 151-REV. 1/1/65

1967 0001848

L-600 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1844 Registered No. 67 1844

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Leona Coleman Lauer

2. DATE AND HOUR OF DEATH: February 20, 1967 | 6 00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 211 E. 33rd Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 211 E. 33rd Street

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: April 3, 1896
9. AGE (In years last birthday): 71
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Coleman
14. MOTHER'S MAIDEN NAME: Ella Ashterly

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 579-07-0172
17. INFORMANT: Personal records
ADDRESS:

18. 420.1 - 260X

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

(B) ARTERIOSCLEROTIC HEART DISEASE — 5 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS — 1 year

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): None
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): None
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from March 17 1964 to February 20 1967, that (I) ~~(we)~~ last saw the deceased alive on Feb 14 1967 and that in (my) ~~(our)~~ opinion death accurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: A.S. Chalfant M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Feb 21. 1967

23C. PHYSICIAN'S NAME (Type): Dr. A.S. CHALFANT M.D.
23D. ADDRESS: 6210 YORK ROAD, BALTIMORE Md 21212

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 23, 1967
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Park
24D. LOCATION (City, town, or county) (State): Parkville, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: R. Lee E. Fagan
25C. FUNERAL DIRECTOR: John Burns' Sons, Towson, Maryland
ADDRESS:

VS 150-REV. 1/1/65

67 000 1844

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Check with Health Department before embalming

V-240

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1845 — Registered No. 67 1845

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Vogel, Albert A.

2. DATE AND HOUR OF DEATH: 2/21/67 10:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore — 6-01
D. STREET ADDRESS (If rural, give location): 11 Kenwood Ave

5. SEX: M — 6. RACE: W — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) — 8. DATE OF BIRTH: 8/9/93 — 9. AGE (In years last birthday): 73 yrs. — If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): X-ray Tech. — 10B. KIND OF BUSINESS OR INDUSTRY: Hospital — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Charles Vogel — 14. MOTHER'S MAIDEN NAME: Theresa Sarina

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: 215-32-1927 — 17. INFORMANT: Paul Vogel (brother) — ADDRESS: 11 Kenwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure
DUE TO
(B) Severe Pulmonary Emphysema
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20A. AUTOPSY? (Yes or No) — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ — 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 18 1967 to Feb. 21 1967, that (I) (we) last saw the deceased alive on Feb. 21 1967 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Suarez M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): NENITA SUAREZ M.D. — 23D. ADDRESS: Church Home & Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 2/24/67 — 24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery — 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967 — 25B. NAME OF REGISTRAR: Robert E. Tarkington — 25C. FUNERAL DIRECTOR: Walters Funeral Home — ADDRESS: Pratt & Strickland

VS 150-REV. 1/1/65

67 020 1850

W-350

BIRTH NO. 67 1846

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1846

1. NAME OF DECEASED (Type or Print): ~~XXXXXXXX~~ ANN WITTEN

2. DATE AND HOUR OF DEATH: FEBRUARY 20 1967 | 12 40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTO

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: — Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 3631 PASKIN PLACE, APT 2B

5. SEX: FEMALE

6. RACE: CAUC.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: NOV 12 1905

9. AGE (In years last birthday): 61

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abraham Kalin

14. MOTHER'S MAIDEN NAME: Zelda Lazarus

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: 240-05-0682

17. INFORMANT: Mr. Morrie Witten

ADDRESS: 3631 Paskin Place, Apt 2B

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC BILIARY CIRRHOSIS — INTERVAL BETWEEN ONSET AND DEATH: 22 yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FEB 18 1967 to FEB 20 1967, that (I) (we) last saw the deceased alive on FEB 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Melvyn B. Lewis M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-20-67

23C. PHYSICIAN'S NAME (Type): MELVYN B. LEWIS M.D.

23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/22/67

24C. NAME of CEMETERY or CREMATORY: Bnai Israel

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Roland E. Fahrney

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.

ADDRESS: 6010 Reist. Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1847 Registered No. 67 1847

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clarke, Mr. James R.

2. DATE AND HOUR OF DEATH: 2/22/67 1:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital Baltimore, Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 26-01

D. STREET ADDRESS (If rural, give location): 5517 Ritter Ave.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 9.29.84

9. AGE (In years last birthday): 82

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mach. retired

10B. KIND OF BUSINESS OR INDUSTRY: Wesco Corp.

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Ray Clarke

14. MOTHER'S MAIDEN NAME: Belle James

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes

(If yes, give war or dates of service): ? Unknown

16. SOCIAL SECURITY NO.: 215.03 3328

17. INFORMANT: Dolores Franz

ADDRESS: 5517 Ritter Ave.

MEDICAL CERTIFICATION

1B. 4467 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive Heart Failure

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C) Benign Nephrosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH ~~(Notify medical examiner)~~

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-18 1967 to 2-22 1967, that (I) (we) last saw the deceased alive on 2-22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: NEVITA SUAREZ M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-22-67

23C. PHYSICIAN'S NAME (Type): Suarez M.D.

23D. ADDRESS: Church Home & Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-25-67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Philip E. Coach

ADDRESS: 1211 Chesaco Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1848 Registered No. 67 1848

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) AGNES JOHNSON

2. DATE AND HOUR OF DEATH 2/3/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 940 S. Sharp St

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2301

D. STREET ADDRESS (If rural, give location) 940 S. Sharp St.

5. SEX Fem

6. RACE Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) 78

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarct — ?

DUE TO Arteriosclerotic C-V Dis

(B)

DUE TO

(C) Senile Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/1/1967 to 2/3/1967, that (I) (we) last saw the deceased alive on 1/20/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED 2/6/67

23C. PHYSICIAN'S NAME (Type) JOHN S. BRATTON M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 2-8-67

24C. NAME of CEMETERY or CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) Balto. (State) Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 24 1967

25B. NAME OF REGISTRAR Robert E. Fairbanks

25C. FUNERAL DIRECTOR I. L. BROWN & SON

ADDRESS 108 W. Montgomery

VS 150-REV. 1/1/65

67 0 0 1 8 5 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

W-452

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 1849

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1849

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lewis Williams

2. DATE AND HOUR PRONOUNCED DEAD: 2. 6. 1967 4:50 PM

CERTIFICATE AMENDED 3-3-67

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-01
D. STREET ADDRESS (If rural, give location): 156 West Hamburg Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	colored	MARRIED	1923-?	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
~~Labor~~ Bricklayer	~~BRICK YARD~~ Refractories Company	Sumter S.C.	U.S.A.

13. FATHER'S NAME: James Williams

14. MOTHER'S MAIDEN NAME: Beatrice Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Willie May ~~Mae~~ Williams
ADDRESS: 11 ~~14~~ Hudson St Sumter S.C.

MEDICAL CERTIFICATION

18. 241X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary asthma

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: ~~Natural causes~~ ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2. 7. 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial Removal	Feb. 12, 1967 2/8/67	Walker Cemetery Sumter	Sumter S.C.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 24 1967	Robert E. Farley, M.D.	Palmer Memorial Chapel ISAIAH L. BROWN & SON	304 S. Main St. Sumter S.C. 108 W. Montgomery

VS 151-REV. 1/1/65

1967000184

G-621

67 1850

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1850

1. NAME OF DECEASED (Type or Print): Elsie Grace Heffner Gross [redacted]

2. DATE AND HOUR OF DEATH: 2/21/67 12 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Carroll Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Taney Town 56-00

D. STREET ADDRESS (If rural, give location): NOT KNOWN

5. SEX: F

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9/9/93

9. AGE (In years last birthday): 73

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Heffner

14. MOTHER'S MAIDEN NAME: [redacted] Sally Staley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Leslie G. Gross [redacted] ADDRESS: Taney Town, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration — INTERVAL BETWEEN ONSET AND DEATH: ? minutes

DUE TO: Pulmonary Embolic

(B) Embolic — ?

DUE TO: ASCVD

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Infected stump ? Lower Step; Diabetes Mellitus

19A. DATE OF OPERATION: 2/6/67 2/13/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Pem. artery embolus

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? — (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 2/16 1967 to 2/21 1967, that (I) (we) last saw the deceased alive on 2/21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B. Ann Ward M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): B. Ann Ward M.D.

23D. ADDRESS: Baltimore, Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. 24, 1967

24C. NAME of CEMETERY or CREMATORY: Reformed Cemetery

24D. LOCATION (City, town, or county) (State): Jefferson, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Donald M. Etchison M. R. Etchison & Son, Frederick, Md.

VS 150-REV. 1/1/65

1967000185B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-15

BIRTH NO. 67 1851

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1851

1. NAME OF DECEASED (Type or Print): HOFFMASTER LEONA M.

2. DATE AND HOUR OF DEATH: Feb. 22nd 1967, 9 10 p.m. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital Baltimore, Maryland. 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: 202 Fourth Ave Baltimore, Md. 21227

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Balto Co 53-00

D. STREET ADDRESS (If rural, give location): 202 4th Ave. Lansdowne, Md.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 11/16/28

9. AGE (In years last birthday): 38

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Crauf

14. MOTHER'S MAIDEN NAME: Jeanette Grumbling

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ✓ (If yes, give war or dates of service): ✓

16. SOCIAL SECURITY NO.: 215-22-0497

17. INFORMANT: Carl Hoffmaster ADDRESS: 202 Fourth Ave (21227)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 054X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) septic shock and

DUE TO

(B) severe acidosis.

DUE TO

(C) Renal Shutdown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Spring Grove Hospital

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 22 1967 to Feb 22 1967, that (I) (we) last saw the deceased alive on Feb 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Zouheir Shama M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): ZOUHEIR SHAMA M.D.

23D. ADDRESS: UNIVERSITY HOSPITAL BALTO, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cem.

24D. LOCATION (City, town, or county) (State): 5829 Ritchie Hwy Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: John J. Cowan & Son Inc

ADDRESS: 901 Hollins St. 23. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-246

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1852 Registered No. 67 1852

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Leo R Ziegler

2. DATE AND HOUR OF DEATH: Feb. 23-1967 | 7 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-07
D. STREET ADDRESS (If rural, give location): 311 S. Caton Ave. - 21229

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2/14/00
9. AGE (In years last birthday): 67
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clendenin Brass Inc.
10B. KIND OF BUSINESS OR INDUSTRY: Supply clerk
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Ziegler
14. MOTHER'S MAIDEN NAME: Rose Callahan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-07-1023A
17. INFORMANT: Mrs Julia Ziegler — ADDRESS: Above

MEDICAL CERTIFICATION

1B. 151X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CA of stomach with — 7 months
DUE TO gastrointestinal hemorrhage

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 2/2 19 67 to 2/23 19 67, that I (we) last saw the deceased alive on 2/23 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. L. Guerrero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/23/67
23C. PHYSICIAN'S NAME (Type): MILAGROS L. GUERRERO M.D.
23D. ADDRESS: Bon Secour Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/67
24C. NAME of CEMETERY or CREMATORY: London Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Robert E. Fagbuna
25C. FUNERAL DIRECTOR: John J. Gowan & Son Inc.
ADDRESS: 901 Hollins St. 23 Md.

VS 150-REV. 1/1/65

W-420

BIRTH NO. 67 1853

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1853

1. NAME OF DECEASED (Type or Print): Francis Elwood Willis

2. DATE AND HOUR OF DEATH: 2/20/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

BB-01

D. STREET ADDRESS (If rural, give location): 5516 Mayview Ave.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 8/11/01

9. AGE (In years last birthday): 65

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Cordova, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Willis

14. MOTHER'S MAIDEN NAME: Clara Wooters

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-12-6342

17. INFORMANT: Ethel H. Kohl

ADDRESS: 5008 E. Eager St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 3271

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Pulmonary Insufficiency — 24 hrs

DUE TO

(B) Acute Pulmonary Emphysema — 10 yrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute UTI

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 19 55 to Feb 20 19 67, that (I) (we) last saw the deceased alive on Feb 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leon E Kassel M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/21/67

23C. PHYSICIAN'S NAME (Type): Leon E. Kassel M.D.

23D. ADDRESS: 3501 St. Paul St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/23/67

24C. NAME of CEMETERY or CREMATORY: Spring Hill Cemetery

24D. LOCATION (City, town, or county) (State): Easton, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Robert C. Altenburg Funeral Home, Inc.

ADDRESS: 6009 Harford Rd.

VS 150-REV. 1/1/65

67 0 0 1 8 5 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1854
M.E. CASE NO. 67 1854
Registered No. 67 1854

1. NAME OF DECEASED (Type or Print): BESSIE SETTLER
2. DATE AND HOUR OF DEATH: FEB. 22, 1967 | 3 P. M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOUSE IN PINES 90 BELVEDERE AVE
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21-20
D. STREET ADDRESS (If rural, give location): 6803 WESTBROOK ROAD
5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: 6/15/1886
9. AGE (In years last birthday): 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ELLIS
14. MOTHER'S MAIDEN NAME: PEARL
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
16. (If yes, give war or dates of service):
SOCIAL SECURITY NO.:
17. INFORMANT: M. MARTIN SETTLER — ADDRESS: SAME

MEDICAL CERTIFICATION

1B. 293X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) coronary occlusion
DUE TO
(B) GI bleeding
DUE TO
(C) anemia

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from (1967 to — 19 , that (I) (we) last saw the deceased alive on 2/21 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leonard M Kristes M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/23/67
23C. PHYSICIAN'S NAME (Type): Leonard M Kristes M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/23/1967
24C. NAME of CEMETERY or CREMATORY: NORTH POINT ROAD
24D. LOCATION (City, town, or county) (State): BALTIMORE MD
25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR:
25C. FUNERAL DIRECTOR: SYLVAN S. LEWIS + SON, INC. ADDRESS: GARRISON, MD

VS 150-REV. 1/1/65

0267 0 0 1 8 5 9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

J-520

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 1855 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 67 1855

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary R. Jones

2. DATE AND HOUR PRONOUNCED DEAD: 2/21/67 | 7:35 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 39 Provident Hospital

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): 938 Whitelock St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	Negro	Single	12-22-1951	15		

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	Pub. Schools	Bennettsville S.C.	USA

13. FATHER'S NAME: Wm. H. Jones

14. MOTHER'S MAIDEN NAME: Mae E. David

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mae E. Jones — ADDRESS: 938 Whitelock St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia following abortion with perforation of uterus

~~DUE TO~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): ?

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ?

21D. TIME OF INJURY (APPROX.): (Month) 2 (Day) ? (Year) 67 (Hour) ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? criminal abortion

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 2/21/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/25/67	Mt Auburn	Baltimore

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 24 1967	Robert E. Fabiano	Marshall A. Harris	138 N. Gilmor St

VS 151-REV. 1/1/65

7 0 0 0 1 8 6 0

W-412

Released on approval of Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1856

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1856

1. NAME OF DECEASED (Type or Print): WALKER, WILLIAM ALBERT

2. DATE AND HOUR OF DEATH: 2-20-67 3:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: ALLEGANY C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): FROSTBURG 51-22
D. STREET ADDRESS (If rural, give location): 22 BRADDOCK ST.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-30-04
9. AGE (In years last birthday): 62
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10B. KIND OF BUSINESS OR INDUSTRY: STORE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM WALKER
14. MOTHER'S MAIDEN NAME: EMILY TAYLOR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO.: 294-07-6268
17. INFORMANT: PATIENT
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 451X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ABDOMINAL AORTIC ANEURYSM — NOTED 3 MO AGO
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OPERATIVE RESECTION OF ANEURYSM

CERTIFICATION APPROVED BY MEDICAL EXAMINER OR ASST. MEDICAL EXAMINER. 7/19/67

19A. DATE OF OPERATION: 2-20-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ABD. ANEURYSM
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 11, 1967 to Feb 20, 1967, that (I) (we) last saw the deceased alive on Feb 20, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles S. Harrison M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-20-67
23C. PHYSICIAN'S NAME (Type): CHARLES S. HARRISON, M. D.
23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-23-67
24C. NAME of CEMETERY or CREMATORY: FBG. MEMORIAL PARK
24D. LOCATION (City, town, or county) (State): FROSTBURG, MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: JOSEPH R. DURST, SR., FROSTBURG, MD.
ADDRESS:

VS 150-REV. 1/1/65

1856

M-460

BIRTH NO. 67 1857

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1857

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BLANCHE MILLER

2. DATE AND HOUR OF DEATH: 2-22-67 | 7:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dukeland Nursing Home, 1501 N. Dukeland Street, Baltimore, Maryland 21216

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 106 N. Monroe Street

20-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Widowed	4/3/95	71 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Private	Harford County	USA

13. FATHER'S NAME: George E. Howe

14. MOTHER'S MAIDEN NAME: Martha Franklin

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215 12 7905

17. INFORMANT: Margaret Brown ADDRESS: 621 N. Carrollton Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — 4 hrs

DUE TO

(B) CEREBRAL ARTERIOSCLEROSIS

DUE TO

(C) HYPERTENSIVE CARDIOVASCULAR DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-10 1966 to 2-22 1967, that (I) (we) last saw the deceased alive on 2-21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thomas W. Harris M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-22-67

23C. PHYSICIAN'S NAME (Type): THOMAS W HARRIS M.D.

23D. ADDRESS: 1824 W. FRANKLIN ST.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/27/67	Mt. Zion Cemetery	Long Green, Md. Balto. Co

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 24 1967	Robert E. Taylor M.D.	Lewis T. Gugan	2707 Ruscombe La Balto. 15, Md

VS 150-REV. 1/1965

S. 420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1858 Registered No. 67 1858

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BARBARA SCHULZ

2. DATE AND HOUR OF DEATH: 2-22-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 418 N. MONTFORD AVE.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 6-03

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 418 N. MONTFORD AVE.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 10-13-1885

9. AGE (In years last birthday): 81

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE HERLER

14. MOTHER'S MAIDEN NAME: MARGARET STARKLAUF

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. Albert J. Schulz

ADDRESS: 418 N. Montford Ave.

MEDICAL CERTIFICATION

18. 442X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Failure — 30 minutes

DUE TO

(B) Hypertensive Cardiovascular Renal Disease — 6 years

DUE TO

(C) Generalized Arteriosclerosis — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 6 1960 to Jan 10 1967, that (I) (we) last saw the deceased alive on Jan 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Israel Rosen M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/23/67

23C. PHYSICIAN'S NAME (Type): Israel Rosen M.D.

23D. ADDRESS: 2413 E. Monument St. Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-25-67

24C. NAME of CEMETERY or CREMATORY: NEW CATHEDRAL CEM.

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Fa[illegible]

25C. FUNERAL DIRECTOR: Harry Miller

ADDRESS: 2334 Jefferson St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B.660 1

BIRTH NO. 67 1859

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1859

1. NAME OF DECEASED (Type or Print): BREWER MARTHA J.

2. DATE AND HOUR OF DEATH: 2. 20. 1967 | 2.40 p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 13-08
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2731 W. 34th ST ~~St~~ Denmeade

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 6-6-1878
9. AGE (In years last birthday): 88
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles F Leonard
14. MOTHER'S MAIDEN NAME: Margaret Emily Sample

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Florence Clark - Same
ADDRESS:

MEDICAL CERTIFICATION

18. 239X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Bronchopneumonia
DUE TO
(B) ~~Into~~ Obstructed hepatitis
DUE TO
(C) Abdominal Tumor

INTERVAL BETWEEN ONSET AND DEATH: 2 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 1.2.1967 19 to 2.20. 19 67, that (I) (we) last saw the deceased alive on 2.20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Milos Radojkovic M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2.20.67
23C. PHYSICIAN'S NAME (Type): MILOS RADOJKOVIC M.D.
23D. ADDRESS: LUTHERAN HOSPITAL, BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-25-67
24C. NAME of CEMETERY or CREMATORY: WoodLawn Cemetery
24D. LOCATION (City, town, or county) (State): ELMIRA, New York

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Ellsworth Armacost
ADDRESS: 4600 Lib Hights Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B. 210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1860 Registered No. 67 1860

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lulu Genevieve Bushby

2. DATE AND HOUR OF DEATH: 2-23-67 | 6:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore 28-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21207
D. STREET ADDRESS (If rural, give location): 5200 Gwynn Oak Avenue

5. SEX: Fe
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 6-23-1882
9. AGE (In years lost birthday): 84
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Joseph A. Woodworth
14. MOTHER'S MAIDEN NAME: Susan Waugh

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-01-9954
17. INFORMANT: Wm T. Bushby
ADDRESS: 5200 Gwynn Oak.

MEDICAL CERTIFICATION

I

1B. 420.1 | 356.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infarction — hours
DUE TO
(B) Arterio-sclerotic cardio-vascular disease — years
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Poss. Ca of the liver

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-23-1967 to 2-23-1967, that (I) (we) last saw the deceased alive on 2-23-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Octavio A Ruiz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): Octavio A Ruiz M.D.
23D. ADDRESS: Bon Secour Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-25-67
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Ellsworth Armacost
ADDRESS: 4600 Liberty Heights

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6700018 6B

W 452 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1861 Registered No. 67 1861

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ~~XXX~~ Martha B.Willms

2. DATE AND HOUR OF DEATH: 2-21-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 709 Hanover Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 2201
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 709 Hanover Street

5. SEX: F
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 9-12-67 (00 ??)
9. AGE (In years last birthday): 67
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Day Worker
11. BIRTHPLACE (State or foreign country): Baltimore-Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Kane
14. MOTHER'S MAIDEN NAME: Martha B.Kane

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Shirley Boardley
ADDRESS: 519-Shar- Street

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) MYOCARDIAL INFARCTION — UNKNOWN
DUE TO
(B) HYPERTENSIVE CARDIO VASCULAR DIS,
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/24/1962 to 2/21/1967, that (I) (we) last saw the deceased alive on 11/16/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/24/67
23C. PHYSICIAN'S NAME (Type): JOHN S. BRAXTON M.D.
23D. ADDRESS: 922 S. SHARP ST. BALT. 20, MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2025-67
24C. NAME of CEMETERY or CREMATORY: Mount Auburn
24D. LOCATION (City, town, or county) (State): Baltimore-City

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Isaiah L.Brown and Son
ADDRESS: 108 Montgomery Street

VS 150-REV. 1/1/65

1967 0 0 1 8 6 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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S-545

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1862 Registered No. 67 1862

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT J. SMOLINSKI

2. DATE AND HOUR PRONOUNCED DEAD: February 23, 1967 12:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Baltimore City Hospital (DOA)

31/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-36

D. STREET ADDRESS (If rural, give location): 1218 Steelton Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
Male	White	Divorced	9-29-1916	50	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Longshoreman	Ship-ceiler	Baltimore, Maryland	U. S. A.

13. FATHER'S NAME: August Smolinski

14. MOTHER'S MAIDEN NAME: Julia Gadomski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	- - - - - - - -	216-09-6316	Mrs. Sadie Kullman	329 S. Folcroft St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: February 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/27/67	St. Stanislaus Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 24 1967	Robert E. Fankhauser	George A. Weber	705 S. Ann St. #21231

VS 151-REV. 1/1/63

1967000 1867

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P-200

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1863 67-01812 Registered No. 67 1863

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DOUGLAS A. PIKA

2. DATE AND HOUR PRONOUNCED DEAD: February 23, 1967 | 4:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31/99 Baltimore City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 844 Mildred Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: Jan. 25, 1967

9. AGE (In years last birthday): If Under 1 Yr. Months | Days: 29 | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - -

10B. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Anthony Pika

14. MOTHER'S MAIDEN NAME: Mary Boncewich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): - - - - - -

16. SOCIAL SECURITY NO.: - - - - -

17. INFORMANT: Anthony Pika ADDRESS: 844 Mildred Avenue #21222

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonitis (SDII) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: February 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/24/67

23C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: George A. Weber ADDRESS: 705 S. Ann St. #21231

VS 151-REV. 1/1/65

1967009018 68

J-250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1864 Registered No. 67 1864

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Milton Jackson

2. DATE AND HOUR OF DEATH: February 19/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 8-07

D. STREET ADDRESS (If rural, give location): 2008 E. Biddle St.

5. SEX: Male 6. RACE: Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married 8. DATE OF BIRTH: Oct 19 1914 9. AGE (In years last birthday): 52 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman 10B. KIND OF BUSINESS OR INDUSTRY: Penna R.R. 11. BIRTHPLACE (State or foreign country): Brookneal Va. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Othe Jackson 14. MOTHER'S MAIDEN NAME: Lillie Britton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Anna Jackson ADDRESS: 2008 E. Biddle St

MEDICAL CERTIFICATION

1B. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial Infarction — Instant

DUE TO

(B) Previous myocardial Infarction — 27 Days

DUE TO

(C) Arteriosclerotic Cardiovascular Disease — 6 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2-25- 1961 to 2-20- 1967, that (I) (~~we~~) last saw the deceased alive on 2-16- 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Eugene H. Owens M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 2-20-67

23C. PHYSICIAN'S NAME (Type): Eugene H. Owens M.D. 23D. ADDRESS: 1735 E. Federal St

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: Feb 22/67 24C. NAME of CEMETERY or CREMATORY: 24D. LOCATION (City, town, or county) (State): Lynchburg Va.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967 25B. NAME OF REGISTRAR: 25C. FUNERAL DIRECTOR: Joseph T. Elliscus ADDRESS: 1129 N. Carlton St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1965

01869

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17-540

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1865 Registered No. 67 1865

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): R. T. HANLEY

2. DATE AND HOUR PRONOUNCED DEAD: February 19, 1967 8:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1751 N. Castle Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05
D. STREET ADDRESS (If rural, give location): 1833 N. Regester Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: May 25, 1930
9. AGE (In years last birthday): 36
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hawkinsville Ga.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Hanley
14. MOTHER'S MAIDEN NAME: Hazel ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hazel Hanley Tifton Ga.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E981X

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of chest
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): house
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Living room 1751 N. Castle Street

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-19-67 8:30 P.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Shot during altercation 8-06

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [ ]

ACTUAL SIGNATURE: Russell S Fisher M.D.
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
DATE SIGNED: February 20, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Remove
23B. DATE: Feb 21/67
23C. NAME of CEMETERY or CREMATORY:
23D. LOCATION (City, town, or county), (State): Tifton Georgia

24A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
24B. NAME OF REGISTRAR: Robert E. Farley
24C. FUNERAL DIRECTOR: Milton E. Ellickson
ADDRESS: 112 W. N. Carolina St

VS 151-REV. 1/1/65

N875.4 67 0 0 1870

J-S 25

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1866 Registered No. 67 1866

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (Sallie) Sarah Johnson

2. DATE AND HOUR OF DEATH 2/19/67 3 20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 8-04

D. STREET ADDRESS (If rural, give location) 2314 E. CHASE ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	NEGROID	MARRIED	8-4-08	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Charlotte Court House Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JAMES MARSHALL

14. MOTHER'S MAIDEN NAME SUE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Valarious Johnson ADDRESS 2314 E. Chase St

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Chronic Cor Pulmonale with myocardial XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

DUE TO XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

insufficiency due to pulmonary fibrosis.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

CH. 2403

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/19 1967 to 2/19 1967, that (I) (we) last saw the deceased alive on 2/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Sherrard Hayes M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 2/19/67

23C. PHYSICIAN'S NAME (Type) SHERRARD HAYES M.D.

23D. ADDRESS THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE Feb 19/67

24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery

24D. LOCATION (City, town, or county) (State) A.A. County Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 24 1967

25B. NAME OF REGISTRAR Robert E. Fahrney

25C. FUNERAL DIRECTOR Milton E. Eichacker ADDRESS 1739 N. Carrollton

VS 150-REV. 1/1/65

THE REMAINS OF SARAH JOHNSON WERE RELEASED TO THE JOHNS HOPKINS HOSPITAL BY DR. SPERTZ

MEDICAL EXAMINER

APPROVAL BY FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-26

BIRTH NO. 67 1867

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1867

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mrs. Katie G. Baker

2. DATE AND HOUR OF DEATH: 2 30 pm 2/23/67 (19) M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 Monte Bello Hosp. Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: a

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 212 23 2203

D. STREET ADDRESS (If rural, give location): 17 South Polaski St.

5. SEX: F

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): (circled) MARRIED

8. DATE OF BIRTH: 2/12/1909

9. AGE (In years last birthday): 57

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: 0

11. BIRTHPLACE (State or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry McGlister

14. MOTHER'S MAIDEN NAME: Annie Simpson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 0

17. INFORMANT: Mrs Annie Roy ADDRESS: 4215 Bonner Rd. Baltimore

MEDICAL CERTIFICATION

1B. 1748 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Leiomyosarcoma of uterus with metastasis to liver

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 13 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/13/1966 to 2/23/1967, that (I) (we) last saw the deceased alive on 2/23/19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hea Rean Lew M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): Hea Rean LEW M.D.

23D. ADDRESS: 102 Upnor Road, Baltimore 212 12

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-27-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county): Arbutus (State): Md.

25A. DATE REC'D BY HEALTH DEPT.:

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: Morton E. Dyott Fitt ADDRESS: 1201 Laurens St.

1 9 6 7 0 0 1 8 7 2

VS 150-REV. 1/1/65

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B-300

BIRTH NO. 67 1868

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1868

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): M.N.(William) GEORGE BOYD

2. DATE AND HOUR PRONOUNCED DEAD: February 23, 1967 10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital (DOA)

39/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): 2433 Madison Avenue

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married-Sep.
8. DATE OF BIRTH: July 11, 1912
9. AGE (In years last birthday): 54
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd Jobs
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frederick, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Boyd
14. MOTHER'S MAIDEN NAME: Laura Boyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes
16. SOCIAL SECURITY NO.: 220-05-6510
17. INFORMANT: Mrs. Madeline Brown ADDRESS: 2307 Reisterstown

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 430.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute bacterial endocarditis

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: February 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-27-67
23C. NAME of CEMETERY or CREMATORY: Balto. National Cem.
23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: Morton & Dyett ADDRESS: F.H. 1701 Laurens St.

VS 151-REV. 1/1/65

1967 0001873

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G-000

67 1869

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1869

1. NAME OF DECEASED (Type or Print): RICHARD I. GUAY

2. DATE AND HOUR PRONOUNCED DEAD: February 22, 1967 5:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 35 Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Massachusetts B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malden V-18

D. STREET ADDRESS (If rural, give location): 30 Whipple Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: March 4, 1932

9. AGE (In years last birthday): 34

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lawrence Guay

14. MOTHER'S MAIDEN NAME: Mary Wilkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 002-02-1335

17. INFORMANT: Mr. Robert Guay ADDRESS: Box 19 Penacook, N. H.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E984X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of abdomen

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): taxicab

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2100 Block E. Pratt Street 20-05

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-22-67 3:45 P.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Shot by police officer

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: February 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Removal

23B. DATE: 2/24/1967

23C. NAME of CEMETERY or CREMATORY: Union Cemetery

23D. LOCATION (City, town, or county) (State): Laconia, New Hampshire

24A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

24B. NAME OF REGISTRAR: Robert E. Fairbanks

24C. FUNERAL DIRECTOR: Wm. J. Tichnor Sons ADDRESS: Balto., Md. North Haven

VS 151-REV. 1/1/65

N879.4 1 9 6 7 0 0 0 1 8 7 4

W-412

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1870 Registered No. 67 1870

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rene G. Wolfsheimer

2. DATE AND HOUR OF DEATH: February 22, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 7308 Park Heights Avenue Apt. A Baltimore, Maryland 21208

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): 7308 Park Heights Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Feb. 9, 1872
9. AGE (In years last birthday): 95 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher - Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Moses B. Gump
14. MOTHER'S MAIDEN NAME: Rachel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Barry Wood — ADDRESS: 2920 Abbey Court

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive heart failure
~~DUE TO~~
(B) Arteriosclerosis
~~DUE TO~~
(C) Hypertension

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify ~~that~~ (I) ~~(this hospital)~~ attended the deceased from Ca. 5 years 19 to Feb 22, 1967, that (I) ~~(we)~~ last saw the deceased alive on 20 Feb 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Louis P. Hamburger Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 23 Feb 1967
23C. PHYSICIAN'S NAME (Type): Louis P. Hamburger Jr. M.D.
23D. ADDRESS: 1001 St Paul St Balto. Md 21202

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 2/24/1967
24C. NAME of CEMETERY or CREMATORY: Green Mount Crematory
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Wm. J. Tichnor & Sons — ADDRESS: Baltimore, Md. North & Pon.

VS 150-REV. 1/1/65

1 9 6 7 0 0 1 8 7 0

D-50

BIRTH NO. 67 1871

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1871

1. NAME OF DECEASED (Type or Print): FRED A. DUNN

2. DATE AND HOUR OF DEATH: February 17 1967 | 1:25 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: CAROLINE Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): PRESTON 56-00

D. STREET ADDRESS (If rural, give location): ROUTE 2 BOX 237A

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED

8. DATE OF BIRTH: April 14, 1956

9. AGE (In years last birthday): 10

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Student

10B. KIND OF BUSINESS OR INDUSTRY: Student

11. BIRTHPLACE (State or foreign country): Easton, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: FERD A. ~~FRED~~ DUNN

14. MOTHER'S MAIDEN NAME: LULA BOYD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Ferd A. Dunn, Preston, Md., RFD

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 204.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

DUE TO

(B) Monocytic leukemia — 7 months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: None

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/13/ 8 7 7 1967 to 2/17 1967, that (I) (we) last saw the deceased alive on 2/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. Swick M.D. — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/17/67

23C. PHYSICIAN'S NAME (Type): H. SWICK M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. 19, 1967

24C. NAME of CEMETERY or CREMATORY: Hill Crest Cemetery

24D. LOCATION (City, town, or county) (State): Federalsburg, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: J. J. Frampton Jr.

ADDRESS: J. J. Frampton and Son, Federalsburg, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-242

BIRTH NO. 67 1872

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1872

1. NAME OF DECEASED (Type or Print): Louis H. McCullough

2. DATE AND HOUR OF DEATH: Feb. 22, 1967 | 10:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLES GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 26-07

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 4703 Shamrock Ave.

49

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 3-10-85

9. AGE (In years last birthday): 82

If Under 1 Yr. Months / Days | If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Fitter

10B. KIND OF BUSINESS OR INDUSTRY: B.+O. Railroad

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Christopher McCullough

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-05-3419

17. INFORMANT: Neal McCullough

ADDRESS: 4703 Shamrock Av. Baltimore 21206 MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 491 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema

~~DUE TO~~

(B) Bronchopneumonia

DUE TO

(C) fractured both lower lobes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from Feb. 21 19 67 to Feb. 22 19 67, that (I) (~~we~~) last saw the deceased alive on Feb. 22 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Dwi Hardy per Dr. M. Friedman

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-22-67

23C. PHYSICIAN'S NAME (Type): MARION FRIEDMAN M.D.

23D. ADDRESS: 5211 Harford Road Baltimore 21214 MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-25-67

24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 24 1967

25B. NAME OF REGISTRAR: Robert E. Fulton

25C. FUNERAL DIRECTOR: Philip E. Gruel

ADDRESS: 1211 Closes Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-360 1

BIRTH NO. 67 1873

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1873

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Thomas Gettier

2. DATE AND HOUR OF DEATH: Feb 23,1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4105 Rondo Ct Baltimore,Md

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-05

D. STREET ADDRESS (If rural, give location): 4105 Rondo Ct

5. SEX: Male

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: June 21,1887

9. AGE (In years last birthday): 79

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk

14. MOTHER'S MAIDEN NAME: UNK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family

ADDRESS: Same

MEDICAL CERTIFICATION

18. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Arteriosclerotic Heart disease

DUE TO

(B) Emphysema Bilateral

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 19 1964 to Feb 23 1967, that (I) (we) last saw the deceased alive on 2/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel Rubin M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/23/67

23C. PHYSICIAN'S NAME (Type): Samuel Rubin M.D.

23D. ADDRESS: 203 E. Patapsco Avenue Baltimore, Md. 21225

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY: St Paul Epic Cem

24D. LOCATION (City, town, or county): Granite (State): Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Ralph E. Fairbanks

25C. FUNERAL DIRECTOR: McCully F H

ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

R-6001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1874 — Registered No. 67 1874

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FREDERICK A. REUWER

2. DATE AND HOUR OF DEATH: Feburary 21.1967 | 7:20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore Gen. Hosp. 43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland — B. COUNTY: Anne Arundel Co. — C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pasadena 52-00 — D. STREET ADDRESS (If rural, give location): Pine Knob Road (High Point)

5. SEX: Male — 6. RACE: White — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married — 8. DATE OF BIRTH: Jan. 1, 1904 — 9. AGE (In years last birthday): 63 — If Under 1 Yr. Months / Days — If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Employed — 10B. KIND OF BUSINESS OR INDUSTRY: Wholesale Produce — 11. BIRTHPLACE (State or foreign country): Baltimore, Maryland — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry J. Reuwer — 14. MOTHER'S MAIDEN NAME: Sophie Geis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no — (If yes, give war or dates of service): ////////////// — 16. SOCIAL SECURITY NO.: 216 32 8689 — 17. INFORMANT: Mrs. Blanche Reuwer (wife) — ADDRESS: Same As #4

MEDICAL CERTIFICATION

260X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Antero. Lateral Myocardial Infarction — 2 weeks

DUE TO

(B) Diabetes mellitus — 5 years

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ — 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/26 1963 to 2/21 1967, that (I) (~~we~~) last saw the deceased alive on 2/17 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: John P. Urlock Jr. M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): JOHN P. URLOCK JR M.D. — 23D. ADDRESS: 1227 Washington Blvd

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: Jan. 25/67 — 24C. NAME of CEMETERY or CREMATORY: Glen Haven Memorial Park — 24D. LOCATION (City, town, or county) (State): Glen Burnie, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967 — 25B. NAME OF REGISTRAR: Robert E. Farley M.D. — 25C. FUNERAL DIRECTOR: Richard V. Singleton — ADDRESS: Singleton Funeral Home, Glen Burnie, Md.

VS 150-REV. 1/1/65

1 2 6 7 0 0 0 1 8 6 0

S-530

BIRTH NO. 67 1875

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1875

1. NAME OF DECEASED (Type or Print): Anna Smith

2. DATE AND HOUR OF DEATH: 2/24/67 | 6.00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 547 S. Paca Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 547 S. Paca Street

5. SEX: F
6. RACE: C.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 1/19/07
9. AGE (In years last birthday): 60
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jim Garrett
14. MOTHER'S MAIDEN NAME: Margaret Jones

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 220-09-6631
17. INFORMANT: Margaret Wilson
ADDRESS: 1522 Argyle Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 181.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF BLADDER — unknown

DUE TO Carcinoma of Bladder

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/4/1966 to 2/24/1967, that (I) (we) last saw the deceased alive on 10/24/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/24/67
23C. PHYSICIAN'S NAME (Type): JOHN S. BRAXTON JR
23D. ADDRESS: 922 S. SHARPE ST. BALT. 30, MD

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvery
24D. LOCATION (City, town, or county) (State): Brooklyn, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: Ralph E. Faulkner
25C. FUNERAL DIRECTOR: Charles A. Rice
ADDRESS: 661 W. Barre St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300

BIRTH NO. 67 1876

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1876

1. NAME OF DECEASED (Type or Print): Lillie B. Scott

2. DATE AND HOUR OF DEATH: 2/15/67 ~~xxxx~~ | 8:45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Catonsville 53-00
D. STREET ADDRESS (If rural, give location): 65 Winters Avenue

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 10/2/98
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wiley Brackett
14. MOTHER'S MAIDEN NAME: Caroline Moore

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Albert Mease ADDRESS: 4212 Ethelwood Ave

MEDICAL CERTIFICATION

18. 171X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiopulmonary Arrest — 1 min
DUE TO
(B) Chronic debilitation — 8 mo.
DUE TO
(C) Metastatic Carcinoma of Cervix — >10 mo.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Age

19A. DATE OF OPERATION: 12/29/66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Intestinal Obstruction
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from Dec 19 1966 to Feb 15 1967, that ~~I~~ (we) last saw the deceased alive on Feb 15 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Arthur C. Burdett M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-15-67
23C. PHYSICIAN'S NAME (Type): Arthur C. Burdett M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/22/67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Arlington S. Phillips ADDRESS: 1727 N. Mound St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

C-358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1877 Registered No. 67 1877

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anna L. Cadden

2. DATE AND HOUR OF DEATH: 2-22-67 | 3 15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1405 Hull St.

24-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Never Married	6-14-1897	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Box Maker	J.E. Smith Paper Box	Maryland	U.S.A.

13. FATHER'S NAME: Anthony P. Cadden

14. MOTHER'S MAIDEN NAME: Margaret V. Burns

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-07-4884

17. INFORMANT: A. Edward Cadden

ADDRESS: 633 E. Fort Avenue

MEDICAL CERTIFICATION

18. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive heart failure — 3 days

DUE TO

(B) Digitalis toxicity — 3 days

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HASCVD. + hypertension

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 18, 1967 to Feb. 22 1967, that (I) (we) last saw the deceased alive on Feb. 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard H Reed M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-22-67

23C. PHYSICIAN'S NAME (Type): Richard H. Reed. M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/25/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 24 1967

25B. NAME OF REGISTRAR: Ruby E. Fahrney

25C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home

ADDRESS: 1501 E. Fort Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530

BIRTH NO. 67 1878

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1878

1. NAME OF DECEASED (Type or Print): DANIEL C. BENNETT

2. DATE AND HOUR OF DEATH: 2/25/67 6 40 PM AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 3-02

D. STREET ADDRESS (If rural, give location): 126 S. EDEN STREET

5. SEX: MALE

6. RACE: COLORED

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 5-2-07

9. AGE (In years last birthday): 59

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Steel mill

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: JOSEPH BENNETT

14. MOTHER'S MAIDEN NAME: CATHERINE GANTT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-26-8797

17. INFORMANT: Wilma Bennett

ADDRESS: 126 S. Eden St.

MEDICAL CERTIFICATION

1B. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) UREMIA

DUE TO

(B)

DUE TO

(C) ? HASCVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/16 1967 to 2/25 1967, that (I) (we) last saw the deceased alive on 2/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ralph R. Rampton M.D. Attending Phys. ☐ Med. Director ☐ Staff*** Phys. ☐

23B. DATE SIGNED: 2/25/67

23C. PHYSICIAN'S NAME (Type): DR. RALPH RAMPTON M.D.

23D. ADDRESS: JHH

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/2/67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Ralph E. Fagan M.D.

25C. FUNERAL DIRECTOR: Wm. L. Whatmough Jr.

ADDRESS: 1701 McCulloh St. Balto. Md.

VS 150-REV. 1/1/65

1 0 7 0 0 1 8 7 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-1656

BIRTH NO. 67 1879

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1879

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): KATHERINE MARIE BROWN

2. DATE AND HOUR OF DEATH: FEB. 25, 1967 8 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital DOA.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21-01
D. STREET ADDRESS (If rural, give location): 852 Mangold ST.

5. SEX: FEMALE
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: Sept. 12, 1906
9. AGE (In years last birthday): 60 — If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Patrick Murphy
14. MOTHER'S MAIDEN NAME: MARIE —
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: NORMAN W. BROWN — ADDRESS: 852 Mangold St.

MEDICAL CERTIFICATION

1B. 260X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cavernous Sinus Thrombosis right — sudden
DUE TO
(B) Abscess right forehead — 5 days
DUE TO
(C) Diabetes Mellitus — 10 years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 6-8 1959 to 2/25 1967, that (I) ~~(we)~~ last saw the deceased alive on Feb 24 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: John P. Urlock Jr. M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/27/67
23C. PHYSICIAN'S NAME (Type): JOHN P. URLOCK JR M.D.
23D. ADDRESS: 1227 Washington Blvd

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-28-67
24C. NAME of CEMETERY or CREMATORY: GLEN HAVEN
24D. LOCATION (City, town, or county) (State): GLEN BURNIE, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Foley M.D.
25C. FUNERAL DIRECTOR: CECIL L. SCHWAB FUNERAL HOME — ADDRESS: Thomas J. Miller 2101 Hudnick Ave.

VS 150-REV. 1/1/65

M-5.2/

2 22 67

BIRTH NO. 67 1880

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1880

1. NAME OF DECEASED (Type or Print) ELLEN Minnie Mansfield

2. DATE AND HOUR OF DEATH 2-22-67 | 9:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-12

D. STREET ADDRESS (If rural, give location) 2806 Keyworth Avenue

5. SEX Female

6. RACE White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married

8. DATE OF BIRTH 12/03/05

9. AGE (In years last birthday) 61

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Caroline County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME R. William Perry

14. MOTHER'S MAIDEN NAME Mary Boom

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Royden Edward Mansfield

ADDRESS 2806 Keyworth Ave.

MEDICAL CERTIFICATION

1B. 204.21

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myelocytic Leukemia — 4 mths

DUE TO

(B) Gram Negative Sepsis — 2 days

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-2 1967 to 2-22 1967, that (I) (~~we~~) ~~last saw~~ the deceased alive on 2-21 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE Richard Maffezzoli M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 2/22/67

23C. PHYSICIAN'S NAME (Type) Richard Maffezzoli M.D.

23D. ADDRESS The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 24 FEB 67

24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery

24D. LOCATION (City, town, or county) (State) Pikesville, Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 27 1967

25B. NAME OF REGISTRAR Robert E. Falgan

25C. FUNERAL DIRECTOR J. F. Lowell Lemmon

ADDRESS 4611 Park Heights Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1881 Registered No. 67 1881

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Wilbur Tyson

2. DATE AND HOUR OF DEATH: Feb. 23, 1967 | 5:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-33
D. STREET ADDRESS (If rural, give location): 2301 Sidney Ave.

5. SEX: M | 6. RACE: W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower | 8. DATE OF BIRTH: 5/1/83 | 9. AGE (In years last birthday): 83 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): electrical engineer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert Tyson

14. MOTHER'S MAIDEN NAME: Georgianna Eagle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): unknown No

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Family | ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 19 1967 to Feb 23 1967, that (I) (we) last saw the deceased alive on Feb. 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. M. Morris, M.D. | Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ | 23B. DATE SIGNED: 2/23/67

23C. PHYSICIAN'S NAME (Type): Dr A.M. Morris M.D. | 23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 2/27/67 | 24C. NAME of CEMETERY or CREMATORY: Meadowridge Cem | 24D. LOCATION (City, town, or county) (State): Elkridge Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967 | 25B. NAME OF REGISTRAR: Robert E. Farley MD | 25C. FUNERAL DIRECTOR: McCully F H | ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1882 Registered No. 67 1882

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anna C. Fowler

2. DATE AND HOUR OF DEATH: February 21, 1967 | 2 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gould's Convalescent Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 4204 Kenwood Avenue-21206

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Dec. 26, 1890
9. AGE (In years last birthday): 76
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Price
14. MOTHER'S MAIDEN NAME: Henrietta

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles T. Fowler
ADDRESS: 4204 Kenwood Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

(B) Arteriosclerosis generalized

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ — Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1963 to 2/21/1967, that (I) (we) last saw the deceased alive on 2/21/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Sadaranda M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/23/67
23C. PHYSICIAN'S NAME (Type): V. SADARANANDA M.D.
23D. ADDRESS: 6801 Belair Rd Balto 6 Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-24-67
24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.:
25B. NAME OF REGISTRAR:
25C. FUNERAL DIRECTOR: John C. Miller Inc-6415 Belair Road.-21206
ADDRESS

VS 150-REV. 1/1/65 1967000188

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-60 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1883 Registered No. 67 1883

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clarey Anna

2. DATE AND HOUR OF DEATH: 2-21-67 10 50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 5434 Cedonia Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	7/23/86	~~79~~ 80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: --- Goodrick

14. MOTHER'S MAIDEN NAME: Elizabeth

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Regina Byrnes — ADDRESS: 5434 Cedonia Ave.-21206

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Ventricular Septal Rupture — 36 hrs

DUE TO

(B) Myocardial Infarction — 48 hrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from Feb 18 1967 to Feb 21, 1967, that (I) ~~(we)~~ last saw the deceased alive on Feb 21 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: A P Weinfeld M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-21-67

23C. PHYSICIAN'S NAME (Type): A. P. Weinfeld M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-24-67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.:

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: John C. Miller Inc — ADDRESS: 6415 Belair Road-21206

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1967000 1889

48-75-24ED

F-520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1881 Registered No. 67 1884

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Latimer Fink (LATIMER FINK)

2. DATE AND HOUR OF DEATH: 2/22/67 1 50 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hosps 4940 Eastern Ave. Baltimore, Md #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-07

D. STREET ADDRESS (If rural, give location): 500 S. Oldham Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: 1888

9. AGE (In years last birthday): 79

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ROLLER

10B. KIND OF BUSINESS OR INDUSTRY: BETH. STEEL CO.

11. BIRTHPLACE (State or foreign country): PERRY CO., MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY H. FINK

14. MOTHER'S MAIDEN NAME: MARY B. COOK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ?

(If yes, give war or dates of service): ?

16. SOCIAL SECURITY NO. 213-04-1053

17. INFORMANT: BCH Records 4940 Eastern Ave. Baltimore, Md. ADDRESS # 21224

MEDICAL CERTIFICATION

1B. E 916.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Burn 40%

INTERVAL BETWEEN ONSET AND DEATH: ~ 90 min

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Anemia Hct 10%

CERTIFICATION APPROVED BY

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☒

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 500 S. Oldham 26-07

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): Feb 22, 1967 1220 A M

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR? bathrobe caught fire

22. I certify that (I) (~~this hospital~~) attended the deceased from 2/22 19 67 to 2/22 19 67, that (I) (~~we~~) last saw the deceased alive on 2/22 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Martin Rabson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): Martin C. Robson M.D.

23D. ADDRESS: 4940 Eastern Ave. Baltimore, Md. 21224 Baltimore City Hosps

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 2-24-67

24C. NAME of CEMETERY or CREMATORY: East Hlg. Crematory

24D. LOCATION (City, town, or county) (State): Hlg. Dav. Pa.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Louis F. Lescaneck

ADDRESS: [illegible]

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released to Hospital by Medical Examiner

1
M-460

67 1885

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 1885

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN F. (Francis) MULLER

2. DATE AND HOUR PRONOUNCED DEAD: February 24, 1967 | 8:44 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 704 E. 21 St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08

D. STREET ADDRESS (If rural, give location): 704 E. 21st St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Divorced	Nov-23-1887	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired from State Board of Health		Tarkio, Missouri	U.S.

13. FATHER'S NAME: John Muller

14. MOTHER'S MAIDEN NAME: Helen Koehler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	none	J.F.Muller (before death)	704-E-21-St.

MEDICAL CERTIFICATION

1B. 422.1 + E903.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of left femur

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 704 E. 21 St. 9-08

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.: 2-11-67

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Fell in yard at home

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED 2-25-67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Cremation	Feb-27-67	GreenMount Cemetery	Baltimore, Md. 21202

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 27 1967	R. G. E. Fa[illegible]	Stewart & Mowen Co.	108-W-North-Av 21201

VS 151-REV. 1/1/65

N 821.01 9 6 7 0 0 0 1 8 9 1

T-460
C-386

BIRTH NO. 67 1886

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1886

1. NAME OF DECEASED (Type or Print): Vanessa Yvette Chester (Taylor)

2. DATE AND HOUR OF DEATH: 23 February 67 6:50 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore city
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1331 Shields Place

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): never married
8. DATE OF BIRTH: 11/12/51
9. AGE (In years last birthday): 15
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): student
10B. KIND OF BUSINESS OR INDUSTRY: high school
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Henry Taylor
14. MOTHER'S MAIDEN NAME: Doris Chester

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: hospital records
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myeloid leukemia — 6 mo.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 20 Feb 1967 to 23 Feb 1967, that ~~(I)~~ (we) last saw the deceased alive on 23 Feb 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Susan L. Howard M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 23 Feb 67
23C. PHYSICIAN'S NAME (Type) M.D.:
23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/28/67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem
24D. LOCATION (City, town, or county) (State): Anne Arundel Cty., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Fagan
25C. FUNERAL DIRECTOR: W.C. MARCH
ADDRESS: 928 E North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-612 1
G 612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1887 Registered No. 67 1887

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH A. GRYBOS = GREBAS

2. DATE AND HOUR OF DEATH: 2-23-67 | 9:18 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1200 Valley St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 2-2-87
9. AGE (In years last birthday): 80
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: George Grebas
14. MOTHER'S MAIDEN NAME: Elizabeth Bitas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 217-18-3388
17. INFORMANT: Little Sisters of the Poor ADDRESS 1200 Valley St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

(A) ? myocardial infarction — 1 day

DUE TO

(B) ASCVD — Yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia, urinary tract infection

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/22/ 19 67 to 2/23 19 67 that (I) (we) last saw the deceased alive on 2/23 19 67 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis F. [illegible] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/24/67
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS M.D.: Mercy Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Philip Herwig Sons
ADDRESS 2024 Orleans St

VS 150-REV. 1/1/66

31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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B-260

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1888 Registered No. 67 1888

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Crescentia M. BECKER

2. DATE AND HOUR PRONOUNCED DEAD: February 23, 1967 2:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3913 Hudson Street
Baltimore, 21224, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore # 21224, 26-09
D. STREET ADDRESS (If rural, give location): 3913 Hudson Street

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: Jan. 21, 1904
9. AGE (In years last birthday): 63
If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: At Home.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Becker
14. MOTHER'S MAIDEN NAME: Frances Kiefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Charles H. Kitzman: Glen Burnie, Md.
ADDRESS: 202 Broadway Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: February 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-27-67.
23C. NAME of CEMETERY or CREMATORY: Sacred Heart Cemetery
23D. LOCATION (City, town, or county) (State): 7401 German Hill Rd. Ba. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
24B. NAME OF REGISTRAR: Robert E. Farber M.D.
24C. FUNERAL DIRECTOR: Charles A. Zeiler
ADDRESS: 901 S. Conkling St. Balto., 21224, Md.

VS 151-REV. 1/1/65

1967000189 4

J-525

67 1889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1889

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FLORENCE ELIZABETH JOHNSON
Florence Elizabeth Johnson

2. DATE AND HOUR OF DEATH: 2/24/67 5:30 (P) M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore. 12-02
D. STREET ADDRESS (If rural, give location): 314 E 33rd St.

5. SEX: F
6. RACE: White.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 10/26/92
9. AGE (In years last birthday): 74
If Under 1 Yr. Months: 4. Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: House wife
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William H. Kirkwood, Sr.
14. MOTHER'S MAIDEN NAME: Gustave

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Patient. ADDRESS:

MEDICAL CERTIFICATION

18. 149.2

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Diffuse Carcinomatosis. — 6 wks.
DUE TO

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/21/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ASD. Distention — Ascites. Exploratory lap. for definitive dx + tx.
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 1/28/67 19 to 2/24 19 67, that I (we) last saw the deceased alive on 2/24 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: D. S. Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/24/67.
23C. PHYSICIAN'S NAME (Type): D. S. SCHWARTZ M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/28/67
24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Mem. Park.
24D. LOCATION (City, town, or county) (State): Balto. Co.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home, Inc. ADDRESS: 6500 York Road-21212

VS 150-REV. 1/1/65

1967000 1895

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-60d 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-03709 67 1890 Registered No. 67 1890

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Cirri, Baby Boy

2. DATE AND HOUR OF DEATH: 2/23/67 9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD B. COUNTY: 6-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 2419 E. Fayette St. #21224.

5. SEX: MALE 6. RACE: WHITE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE 8. DATE OF BIRTH: 2/15/67 9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 8 If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Balto. Md 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank J. Cirri 14. MOTHER'S MAIDEN NAME: Regina Hettel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): 16. SOCIAL SECURITY NO.: 17. INFORMANT: FRANK J. CIRRI ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity c aspiration pneumonia

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION: none 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: none 20A. AUTOPSY? (Yes or No): yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/15 1967 to 2/23 1967, that (I) (we) last saw the deceased alive on 2/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W E Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 2/23/67.

23C. PHYSICIAN'S NAME (Type): W.E. SCHWARTZ M.D. 23D. ADDRESS: Mercy Hosp. Balto., MD.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL 24B. DATE: 2-25-67. 24C. NAME of CEMETERY or CREMATORY: SACRED HEART CEM. 24D. LOCATION (City, town, or county) (State): 7401 GERMAN HILL RD. BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967 25B. NAME OF REGISTRAR: Robert E. Fahrney 25C. FUNERAL DIRECTOR: Charles L. Geiler ADDRESS: 901 S. CONKLING ST. BALTO., 24, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

47-82-98TN

B-420 67 1891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1891

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA BLAKE

2. DATE AND HOUR OF DEATH: 2/25/67 | 4:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 24-04

D. STREET ADDRESS (If not, give location): 110 BLOOMSBURY STREET 21230

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7-12-97

9. AGE (In years last birthday): 69

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Rolston

14. MOTHER'S MAIDEN NAME: WILKERSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: BCH: RECORDS

ADDRESS: 4940 EASTERN AVENUE

MEDICAL CERTIFICATION

1B. 334 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) cerebrovascular disease

DUE TO

(B) arteriosclerosis

DUE TO

(C) hypertension

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

UTI - pos sepsis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ~~2/25~~ 10/3 19 66 to 2/25 19 67, that (I) (we) last saw the deceased alive on 2/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Peter J. Rosen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/25/67

23C. PHYSICIAN'S NAME (Type): DR. PETER J. ROSEN M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE BALTO. MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3 1 67

24C. NAME of CEMETERY or CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Mc Cully

ADDRESS: 130 E. Fort Ave

VS 150-REV. 1/1/65

1 5 7 0 0 1 8 2 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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A-636

BIRTH NO. 67 1892

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1892

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William C. Arterburn

2. DATE AND HOUR PRONOUNCED DEAD: 2/18/67 7:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jessup-rural 63-00
D. STREET ADDRESS (If rural, give location): 644 Savage Guilford Rd.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: March 2 1914
9. AGE (In years last birthday): 52
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): automotive inspector
10B. KIND OF BUSINESS OR INDUSTRY: US Government
11. BIRTHPLACE (State or foreign country): Laurel Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John David Arterburn
14. MOTHER'S MAIDEN NAME: Ellnetta Earp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): WW2
16. SOCIAL SECURITY NO.: 215-05-9383
17. INFORMANT: Mildred Arterburn
ADDRESS: Jessup Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/19/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-22-67
23C. NAME OF CEMETERY or CREMATORY: St Johns Lutheran
23D. LOCATION (City, town, or county) (State): Pfeffer's Corner, Md

24A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: DeWitt Donaldson, Laurel Md
ADDRESS

VS 151-REV. 1/1/65

1967 0001892

K-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1893

Registered No. 67 1893

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALEXANDER J. KALLAY
Kallay, Alexander John

2. DATE AND HOUR OF DEATH: 2/23/67 8:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-04
D. STREET ADDRESS (If rural, give location): 3600 5th St 25

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7-17-87 2/13/87 X
9. AGE (In years last birthday): 79 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith
10B. KIND OF BUSINESS OR INDUSTRY: Eastern Stainless Steel
11. BIRTHPLACE (State or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Paul Kallay
14. MOTHER'S MAIDEN NAME: Susanna Bartos

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-12-6224
17. INFORMANT: Mrs. Mary Kallay
ADDRESS: 3600 Fifth St., Baltimore 25

CAUSE OF DEATH

MEDICAL CERTIFICATION

1B. 518 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pul - Emphysema
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on 2/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chang Kue Kuhn M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/23/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-27-1967
24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery
24D. LOCATION (City, town, or county) (State): Ritchie Hgwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: George J. Gonce
ADDRESS: 4001 Ritchie Hgwy., Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1967 0001899

S-160

BIRTH NO. 67 1894

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1894

1. NAME OF DECEASED (Type or Print): SPURRY, WILLIAM L.

2. DATE AND HOUR OF DEATH: 2-24-67 11:15 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Balto. Gen. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~1228 LIGHT ST~~ MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE #30 23-02
D. STREET ADDRESS (If rural, give location): 1228 LIGHT ST

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 11-28-88
9. AGE (In years last birthday): 78
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: Paper Hanger
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM SPURRY
14. MOTHER'S MAIDEN NAME: EMMA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family
ADDRESS: Same

MEDICAL CERTIFICATION

1B. 153.8 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) CARCINOMA OF COLON
DUE TO
WITH METASTASIS
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
SEVERE ARTERIOSCLEROSIS WITH ABDOMINAL AORTIC ANEURYSM

19A. DATE OF OPERATION: 2-24-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: INTESTINAL OBSTRUCTION
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ ~~Not While At Work~~ ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 2-22 1967 to 2-24 1967, that ~~(I)~~ (we) last saw the deceased alive on 2-24 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: William J. Marek M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2-25-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2 28 67
24C. NAME of CEMETERY or CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Brooklyn, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Fulham
25C. FUNERAL DIRECTOR: Mc Cully
ADDRESS: 130 E. Fort Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

William J. Monk

6-650

Dr. 9.3735

BIRTH NO. 67 1895

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1895

1. NAME OF DECEASED (Type or Print): Daisey M. Green

2. DATE AND HOUR OF DEATH: February 22, 1967 5.15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1115 Weldon Avenue Balto. Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-07

D. STREET ADDRESS (If rural, give location): 1115 Weldon Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Aug. 27, 1879

9. AGE (In years last birthday): 87

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Kearney

14. MOTHER'S MAIDEN NAME: Henrietta Mays

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Marjorie McCauley ADDRESS: 1115 Weldon Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 33/X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebra vascular accident

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug. 1966 to Feb. 22 1967, that (I) (we) last saw the deceased alive on Feb. 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Reuben Hoffman M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2-24-67

23C. PHYSICIAN'S NAME (Type): Reuben Hoffman M.D.

23D. ADDRESS: 846 W 36th. Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-25-67

24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery

24D. LOCATION (City, town, or county) (State): Balto. Co Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Taylor

25C. FUNERAL DIRECTOR: Burgee Funeral Home Lynn Burgee Jones ADDRESS: 3631 Falls Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1896 Registered No. 67 1896

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MILLER HELEN M

2. DATE AND HOUR OF DEATH: 2-22-67 12.40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLSE GENERAL HOSPITAL 49

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: ~~BALTIMORE~~ U.S.A
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-61
D. STREET ADDRESS (If rural, give location): 538 WYNOAKE AVE. 21218

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 2-13-08
9. AGE (In years last birthday): 62
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales lady
10B. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: GEO. HENRY BLATCHLEY
14. MOTHER'S MAIDEN NAME: LAVINIA BLATCHLEY McCauley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214209948
17. INFORMANT: Lee R. Miller ADDRESS: 538 Wynoke Ave 21218

MEDICAL CERTIFICATION

1B. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBRAL HEMORRHAGE DUE TO — 3 days
DUE TO POSSIBLE METASTATIC CARCINOMA
(B) CARCINOMA OF RIGHT LUNG
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-20 1967 to 2-22 1967, that (I) (we) last saw the deceased alive on 2-22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chanthana Suddhimondala M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-22-67

23C. PHYSICIAN'S NAME (Type): THEODORE J. GRAZIANO M.D.
23D. ADDRESS: 2802 HARFORD RD. 21218

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-25-67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
26C. FUNERAL DIRECTOR: Burgen Funeral Home ADDRESS: 3631 Falls Rd
By Thomas W. Lance Jr

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-520 1

BIRTH NO. 67 1897

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1897

1. NAME OF DECEASED (Type or Print): BERNICE YOUNG

2. DATE AND HOUR PRONOUNCED DEAD: February 22, 1967 7:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Sinai Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-41

D. STREET ADDRESS (If rural, give location): 5554 Elderon Avenue

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced (specify))	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Married	10-7-29	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	U.S.A.

13. FATHER'S NAME: A. Montgomery

14. MOTHER'S MAIDEN NAME: Teresa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Daniel Young ADDRESS: 5554 Elderon Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

138.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary sarcoidosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: February 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2-27-67	Baltimore Nat'l. Cem.	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 27 1967	Rose Fridman	Kelson Funeral Home	1348 Calhoun St.

VS 151-REV. 1/1/65

1967 0 0 1 9 0 3

P-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1898 Registered No. 67 1898

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sadie Price

2. DATE AND HOUR OF DEATH: 2/21/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 638 Pitcher St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 638 Pitcher St.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Widowed	4/29/91	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Emma Walker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No.
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Vernice Carter ADDRESS: 638 Pitcher St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — 1 mo
DUE TO
(B) Hypertensive Heart Disease — 1 yr
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/22/66 19 to 2/21/67 19, that (I) (we) last saw the deceased alive on 2-21-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/23/67
23C. PHYSICIAN'S NAME (Type): G. Franklin Phillips M.D.
23D. ADDRESS: 548 McMechen St Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/24/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State): Anne Arundel Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1967 0 1 9 0 4

M-166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1899 Registered No. 67 1899

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lottie Mobray.

2. DATE AND HOUR OF DEATH: 2-23-67 | 3:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp. 40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: 1602
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21217.
D. STREET ADDRESS (If rural, give location): 1313 Lanvale St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	Negro	Widow.	3-18-80	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Byrd
14. MOTHER'S MAIDEN NAME: Mary.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James Mobray ADDRESS: 1313 Lanvale St.

MEDICAL CERTIFICATION

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CHF — 5 days
DUE TO
(B) ASCVD. — years
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2-17 1967 to 2-23 1967, that ~~(I)~~ (we) last saw the deceased alive on 2-23 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard H. Reed M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2-23-67.
23C. PHYSICIAN'S NAME (Type): Richard H. Reed M.D.
23D. ADDRESS: 1213 Light Street.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-28-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Ruby E. Fauntroy
25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-1601

BIRTH NO. 67 1900

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1900

1. NAME OF DECEASED (Type or Print): COOPER, ALBERT ROBERT

2. DATE AND HOUR OF DEATH: 2-25-67 | 7:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1901
D. STREET ADDRESS (If rural, give location): 329 NORTH BRUCE STREET

5. SEX: Male
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6-5-96
9. AGE (In years last birthday): 70
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BANK WORKER
10B. KIND OF BUSINESS OR INDUSTRY: BANKING
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN COOPER
14. MOTHER'S MAIDEN NAME: JOSEPHINE ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown. If yes, give war or dates of service): UNKNOWN WW I
16. SOCIAL SECURITY NO.: 212-05-8084A
17. INFORMANT: PATIENT ADDRESS:

MEDICAL CERTIFICATION

1B. 450.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CHRONIC URINARY TRACT INFECTION — WEEKS
DUE TO
(B) INFECTED A-K AMPUTATION STUMP — 2 WEEKS
DUE TO
(C) MARKED ARTERIOSCLEROSIS — YEARS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: JAN 28, 1967
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: GANGRENE & INFECTED LEG
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 17, 1967 to Feb 25, 1967, that (I) (we) last saw the deceased alive on Feb 25, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles S. Harrison M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-25-67
23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS M.D.: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-3-67
24C. NAME of CEMETERY or CREMATORY: BALTO NATIONAL
24D. LOCATION (City, town, or county) (State): BALTO MD

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Lachman
25C. FUNERAL DIRECTOR: Marshall R. Hayes
ADDRESS: 638 N Gilmor St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 1900

5-530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1901 Registered No. 67 1901

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SMITH, CHARLES

2. DATE AND HOUR OF DEATH: 2-25-67 | 9 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 17 17-02

D. STREET ADDRESS (If rural, give location): 1220 Druid Hill Avenue

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 6-5-99

9. AGE (In years last birthday): 67

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: TRANSFER Co. ~~UNKNOWN~~

11. BIRTHPLACE (State or foreign country): ALABAMA-USA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 193-16-5733

17. INFORMANT: VIOLA SMITH (WIFE) ADDRESS: S/A

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Embolus, suspected — 35 minutes

DUE TO

(B) Congestive heart failure — 4-5 years

DUE TO

(C) ASCVD, pulm. hypertension and aortic insuff. — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchitis & Emphysema

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: None

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): No

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): No

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): No

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-18-67 19 to 2-25 19 67, that (I) (we) last saw the deceased alive on 2-25-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Timothy K. Gray M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-25-67

23C. PHYSICIAN'S NAME (Type): TIMOTHY KENNEY GRAY M.D.

23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/2/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): BALTO MD

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Marshall P. Flory ADDRESS: 638 N. Gilmor St

0 1 0 0 7

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525

BIRTH NO. 67 1902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1902

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Len Jenkins

2. DATE AND HOUR OF DEATH: Feb 23 1967 | 5:50 pm

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 802 S. Sharpe St.

5. SEX: M
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Sept-1916
9. AGE (In years last birthday): 50
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Contractors Supply
11. BIRTHPLACE (State or foreign country): N. Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Jenkins
14. MOTHER'S MAIDEN NAME: Pattie High.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 231-09-7391
17. INFORMANT: Estelle J. Jones Rt 4 Zebulon N.C.

MEDICAL CERTIFICATION

1B. 162.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) metastatic ~~[illegible]~~ carcinoma ~~[illegible]~~ 1 yr at least
DUE TO

(B) Carcinoma of lung (oat cell)
DUE TO

(C) Probably smoking by Hx.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2-23-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Tracheotomy for lymph nod Bx; bronchial toilet
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 20 1967 to Feb. 23 1967, that (I) (~~saw~~) last saw the deceased alive on Feb. 23 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Richard H Reed M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2-25-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 2/28/67
24C. NAME of CEMETERY or CREMATORY: High
24D. LOCATION (City, town, or county) (State): Zebulon - N.C.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Montgomery P. Hayes
ADDRESS: 638 N Gilmor St

VS 150-REV. 1/1/65

1 9 6 7 0 0 0 1 9 0 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

513
420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1903 Registered No. 67 1903

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY BONAVITA SR. SSND HOLZSCHUH

2. DATE AND HOUR OF DEATH: 2-19-67 10²⁵ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 10-02
D. STREET ADDRESS (If rural, give location): 901 N. ASQUITH ST

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NM
8. DATE OF BIRTH: 5-18-92
9. AGE (In years last birthday): 74
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RELIGIOUS EDUCATOR
10B. KIND OF BUSINESS OR INDUSTRY: EDUCATION
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: OTTO HOLZSCHUH
14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-54-3464
17. INFORMANT: CONVENT RECORDS ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CONGESTIVE HEART FAILURE
DUE TO
(B) MYOCARDIAL INFARCT — 9 days
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 2-10 19 67 to 2-19 19 67, that ~~I~~ (we) last saw the deceased alive on 2-19 19 67 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: William T. Mason M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-19-67
23C. PHYSICIAN'S NAME (Type): WILLIAM T. MASON M.D.
23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2-22-67
24C. NAME of CEMETERY or CREMATORY: SISTERS CEMETERY
24D. LOCATION (City, town, or county) (State): GLEN ARM, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: RAYMOND J. CURRAN ADDRESS: 817 SCARLETT DR. TOWSON, MARYLAND 21204

VS 150-REV. 1/1/65

1967 0021903

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-2451

BIRTH NO. 67 1904

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1904

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): William S. Kisling

2. DATE AND HOUR OF DEATH: FEB. 24 1967 2:30A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 HARFORD GARDENS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21214 27-03

D. STREET ADDRESS (If rural, give location): 5006 CATALPHA Rd.

5. SEX: M

6. RACE: CAU

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: Feb. 18, 1882.

9. AGE (In years last birthday): 85

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY: Box Company

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Kisling

14. MOTHER'S MAIDEN NAME: Anna ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-07-8650

17. INFORMANT: Mrs. Doris Sowinski

ADDRESS: (Same)

MEDICAL CERTIFICATION

1B. 334 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic Heart Disease

DUE TO

(B) Congestive failure

DUE TO

(C) Cerebral arteriosclerosis

and arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Static pneumonia

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): —

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ ~~CAUSE~~ OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 15 1966 to Feb 24 1967, that (I) (~~we~~) last saw the deceased alive on Feb 20 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Donald W. Mintzer M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/24/67

23C. PHYSICIAN'S NAME (Type): DONALD W. MINTZER M.D.

23D. ADDRESS: 3009 EVERGREEN AVE BALTO Md 21214

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/27/67.

24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery

24D. LOCATION (City, town, or county) (State): Glenburnie, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: R. Q. & E. Fahey

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

VS 150-REV. 1/1/65

0 0 0 1 9 1 0

S-5301

BIRTH NO. 67 1905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1905

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALICE BEATRICE SMITH

2. DATE AND HOUR OF DEATH: 2/24/67 | 0 15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21218 12-02
D. STREET ADDRESS (If rural, give location): 3311 ABELL AVENUE

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow ~~M~~
8. DATE OF BIRTH: 04-22-97
9. AGE (In years last birthday): ~~70~~ 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Garment Factory
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJAMIN DE ROSA
14. MOTHER'S MAIDEN NAME: CHRISTINE SCHAEFFER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-01-2787
17. INFORMANT: Mrs. Betty Stover, 58 Burkleigh Rd. Balto. #4 — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 02-15 1967 to 02-24 1967, that (I) (we) last saw the deceased alive on 02-23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-24-67
23C. PHYSICIAN'S NAME (Type): ZOLTAN ZARDAY, M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/67.
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE RECD BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214 — ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-1631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1906 Registered No. 67 1906

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Albert Clifton Roberts

2. DATE AND HOUR OF DEATH: Feb. 23, 1967 | 5:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital

28 Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-44

D. STREET ADDRESS (If rural, give location): 3113 Wisteria Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	9/22/90	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	U.S.N.	Md.	USA

13. FATHER'S NAME: John Roberts

14. MOTHER'S MAIDEN NAME: Mollie Simmons

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	USN 1910-1945	218-09-5194	Records- US PHS Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

(B) Arteriosclerotic cardiovascular disease — Years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 30 1967 to Feb. 23 1967, that (I) (we) last saw the deceased alive on Feb. 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael E. Pelczar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/24/67

23C. PHYSICIAN'S NAME (Type): Michael E. Pelczar, SA Surgeon (R) M.D.

23D. ADDRESS: US Public Health Service Hospital, Balto, Md.

RGB

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/27/67	Baltimore National Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 27 1967	Robert E. Fahrney	Leonard J. Ruck Inc.	Balto. Md.

VS 150-REV. 1/1/65

0 1 9 1 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
S-155

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 1907 Registered No. 67 1907

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William M. Shipman

2. DATE AND HOUR PRONOUNCED DEAD: 2/24/67 | 8:00 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-05
D. STREET ADDRESS (If rural, give location): 6113 Sefton Ave.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: January 22, 1905.
9. AGE (In years last birthday): 62 ~~xx~~
If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Phillip Shipman
14. MOTHER'S MAIDEN NAME: Daisy Stryker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 174-10-6564
17. INFORMANT: Mrs. Delia D. Shipman
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: R
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 2/24/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2/27/67.
23C. NAME of CEMETERY or CREMATORY: Dulaney Valley Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 9 1 3

W-366

67 1908

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1908

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANNIE LAURA SNOW WOODROW

2. DATE AND HOUR OF DEATH: February 22, 1967. 8 4. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1307 Argonne Drive

60

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-02

D. STREET ADDRESS (If rural, give location): 1307 Argonne Drive

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: July 14, 1874.

9. AGE (In years last birthday): 92

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Francis Snow

14. MOTHER'S MAIDEN NAME: Sarah Melinda Stevens

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Mrs. Katherine S. Woodrow Currin ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Edema of Lungs — 1 hour

DUE TO

(C) Arteriosclerotic cardiovascular Disease — 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1966 19 to Feb. 22 19 67, that (I) (we) last saw the deceased alive on Feb. 22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Homer U. Todd M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/23/67

23C. PHYSICIAN'S NAME (Type): Homer U. Todd M.D.

23D. ADDRESS: 2108 St. Paul Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/24/67.

24C. NAME of CEMETERY or CREMATORY: Cambridge Cemetery

24D. LOCATION (City, town, or county) (State): Cambridge, Maryland.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS:

VS 150-REV. 1/1/65

1967 0 0 1 9 1 4

D-41b

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1909 Registered No. 67 1909

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SANTINA DOLFI

2. DATE AND HOUR OF DEATH: February 23, 1967. 7:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (Union Memorial DOA) 4407 Parkmont Avenue

4/4/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21206 26-01
D. STREET ADDRESS (If rural, give location): 4407 Parkmont Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: October 6, 1891.
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Salvatore Glorioso
14. MOTHER'S MAIDEN NAME: Unk. Cimino
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 177-01-1302B
17. INFORMANT: Mr. John Dolfi ADDRESS: (Same)

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarction — 8 weeks
DUE TO
(B) Arteriosclerotic Cardiovascular Disease — 10 years
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 12 1964 to Feb. 23 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 21 1967 and that In(my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Adam Swiss M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Feb. 24, 1967
23C. PHYSICIAN'S NAME (Type): ADAM G. SWISS M.D.
23D. ADDRESS: 6232 BELAIR RD., BALTIMORE, MD. 21206

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/67.
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

1967000915

H-630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1910 Registered No. 67 1910

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles Hurt

2. DATE AND HOUR OF DEATH: 2.24.67 10:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 704

D. STREET ADDRESS (If rural, give location): 1031 North Wolfe Street

5. SEX: 59 Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 5/30/07

9. AGE (In years last birthday): 59

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greenbay Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Silas Hurt

14. MOTHER'S MAIDEN NAME: Mary Clark

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Odessa Hurt ADDRESS: 1031 N. Wolfe St

MEDICAL CERTIFICATION

18. 241X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Status Asthmatiaus

INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2.23 19 67 to 2.24.67 19 , that (I) (we) last saw the deceased alive on 2.24.67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert M. Winslow M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2.24.67

23C. PHYSICIAN'S NAME (Type): Robert M. Winslow M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State): Greenbay Virginia

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Jonah T. Erickson ADDRESS: 1129 N. Carlisle St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1911 Registered No. 67 1911

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Felder, Susie Daisy

2. DATE AND HOUR OF DEATH: 3.10 pm. Feb 24. 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 413 East 22nd St.

12-04

44

5. SEX: F
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 04-02-21
9. AGE (In years last birthday): 45
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Manning S. C.
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Lincoln Felder
14. MOTHER'S MAIDEN NAME: Tora King

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Carrie English ADDRESS: 412 E 22nd St

MEDICAL CERTIFICATION

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11.00pm. Feb 20 1967 to 3.10pm Feb 24 1967, that (I) (we) last saw the deceased alive on 3.10 pm. Feb 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Won Song M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Feb 24 /67
23C. PHYSICIAN'S NAME (Type): SANG WON SONG M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: March 1/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Milton E Gladhill
ADDRESS: 1129 N. Carlton St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-62-1

BIRTH NO. 67 1912

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1912

1. NAME OF DECEASED (Type or Print): LELIA P. PRICE

2. DATE AND HOUR OF DEATH: FEBRUARY 22, 1967 2:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROVIDENT HOSPITAL

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-03

D. STREET ADDRESS (If rural, give location): 2254 MADISON AVENUE

5. SEX: FEMALE

6. RACE: COLORED

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: APRIL 30, 1883

9. AGE (In years last birthday): 83

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): HALIFAX CO., VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JACOB PRICE

14. MOTHER'S MAIDEN NAME: LIZA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-32-4271A

17. INFORMANT: WILLIAM E. SPENCER * ADDRESS: 2612 N. LONGWOOD ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4.9.1964 to 2.22.1967, that (I) (~~we~~) last saw the deceased alive on 2.22.1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: James D. Carr M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2.23.67

23C. PHYSICIAN'S NAME (Type): J.D. CARR M.D.

23D. ADDRESS: 1427 Madison Ave Baltimore Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-25-67

24C. NAME of CEMETERY or CREMATORY: ARBUTUS MEMORIAL PARK

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: CHARLES R. LAW ADDRESS: 802 MADISON AVE.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-451

BIRTH NO. 67 1913

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1913

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Sidonia ~~Sedonia~~ Collins

2. DATE AND HOUR OF DEATH: 2-24-67 | 2:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 16-01

D. STREET ADDRESS (If rural, give location): 822 N. Carrollton Avenue

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 10-10-1873

9. AGE (In years last birthday): 93 yrs.

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto., Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Parker

14. MOTHER'S MAIDEN NAME: Charlotte Gregory

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ruth C. Toney - Long Beach, Calif. ADDRESS:

MEDICAL CERTIFICATION

18. 420101

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Ventricular Fibrillation

DUE TO

(B) Atrial Fibrillation

DUE TO

(C) Arteriosclerotic Heart Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 20, 1967 to February 24, 1967, that (I) (we) last saw the deceased alive on February 24, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Khaly, M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-25-67

23C. PHYSICIAN'S NAME (Type):

23D. ADDRESS: M.D. 1514 Division Street Balto., Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-27-67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Charles R. Law ADDRESS: 802 Madison Ave.

01920

VS 150-REV. 1/1/65

M-610

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1914

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1914

1. NAME OF DECEASED (Type or Print): Murphy - Carl J.

2. DATE AND HOUR OF DEATH: 2/25/67 | 5 40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL
33 BALTIMORE, MD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-03
D. STREET ADDRESS (If rural, give location): 2406 OVERLAND AVE

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 1-17-89
9. AGE (In years last birthday): 78
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Publisher
10B. KIND OF BUSINESS OR INDUSTRY: News Paper
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN H. MURPHY
14. MOTHER'S MAIDEN NAME: MARTHA E. HOWARD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-01-9887
17. INFORMANT: Lillian P. Murphy - 2406 Overland Ave.
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 18. 330 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid hemorrhage
DUE TO
(B) HBP
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to 2/25 19 67, that (I) (we) last saw the deceased alive on 2/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: N Owellen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/25/67
23C. PHYSICIAN'S NAME (Type): RICHARD J. OWELLEN M.D.
23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-1-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 27 1967
25B. NAME OF REGISTRAR: Ralph E. Tarquino
25C. FUNERAL DIRECTOR: Charles R. Law
ADDRESS: 802 Madison Ave.

921

VS 150-REV. 1/1/65

T-460

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was the regular attendant on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final dispositian is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1915 Registered No. 67 1915

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Blanche O. Tyler

2. DATE AND HOUR OF DEATH: 2-24-67 | 1 45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-04

D. STREET ADDRESS (If rural, give location): 2007 Wheeler Avenue

5. SEX: Female

6. RACE: ~~Wht~~ Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12/14/01

9. AGE (In years last birthday): 65

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Broadnax Co., Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas Crayton

14. MOTHER'S MAIDEN NAME: Julia Crayton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Joseph Tyler 2007 Wheeler Ave.

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 199.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma — 1 yr 2 mo

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 2-1- 1967 to 2-24- 1967, that (I) ~~(we)~~ last saw the deceased alive on 2-24 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: A P Weinfeld M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-24-67

23C. PHYSICIAN'S NAME (Type): A. P. Weinfeld M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/28/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: R. S. Fogleman

25C. FUNERAL DIRECTOR: Charles R. Law-802 Madison Ave

ADDRESS

VS 150-REV. 1/1/65

0 1 9 2 2

P-6601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1916 Registered No. 67 1916

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edmond Pryor (EDMUND A. PRYOR)

2. DATE AND HOUR OF DEATH: Feb. 21, 1967 5 02 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University of Maryland Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 13-03

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 2545 McCULLOH ST.

5. SEX: M

6. RACE: COL

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: JULY 23, 1888

9. AGE (In years last birthday): 78

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELEVATOR OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): FARMVILLE VA.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: MATT PRYOR

14. MOTHER'S MAIDEN NAME: SALLIE CAREY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: FLORENCE PRYOR ADDRESS: S/A

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Acute Myocardial Infarction

DUE TO

(B) Coronary Artery Disease

DUE TO

(C) ASCVD

INTERVAL BETWEEN ONSET AND DEATH: ??

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 19 1967 to Feb. 21 1967, that (I) (we) last saw the deceased alive on Feb. 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R H Anderson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Feb. 21, 1967

23C. PHYSICIAN'S NAME (Type): R. H. Anderson M.D.

23D. ADDRESS: University Hospital Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-24-67

24C. NAME of CEMETERY or CREMATORY: MOUNT AUBURN

24D. LOCATION (City, town, or county) (State): BALTO, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: I. G. Brown & Son ADDRESS: 123 W. Montgomery St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

C-608

BIRTH NO. 67 1917

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1917

1. NAME OF DECEASED (Type or Print): MARY CARR

2. DATE AND HOUR OF DEATH: 2-24-67 | 3:26 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Md. Genl Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: —

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 23-32

D. STREET ADDRESS (If rural, give location): 2710 Sethlow Rd

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPARATED

8. DATE OF BIRTH: 11-23-35

9. AGE (In years last birthday): 31

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Abe Ricks

14. MOTHER'S MAIDEN NAME: Williams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-32-5246

17. INFORMANT: (Sister) Alice McKenny ADDRESS:

MEDICAL CERTIFICATION

18. 464X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary Emboli (Multiple) — INTERVAL BETWEEN ONSET AND DEATH: 2d.

DUE TO

(B) Thrombophlebitis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-22 1967 to 2-24 1967, that (I) (we) last saw the deceased alive on 2-24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-24-67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-28-67

24C. NAME of CEMETERY or CREMATORY: Mt. Calvary

24D. LOCATION (City, town, or county) (State): A.A. Co., Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Marshall W. Jones, Jr. 1735 Harford Ave. ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1918 Registered No. 67 1918

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FANNIE E. PLEET

2. DATE AND HOUR OF DEATH: 2-21-67 | 7 45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 3501 St. Paul Street, Marylander Apts., 1037

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	4/9/1893	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Manko
14. MOTHER'S MAIDEN NAME: Isabelle Reese

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Mr. Emanuel E. Pleet, 3501 St. Paul Street — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 570.3
(A) Irreversible Shock, Pneumonia, Atelectasis — 1 day
DUE TO
(B) Recurrent Paralytic Ileus — 1 week
DUE TO
(C) Strangulated Volvulus, Small Bowel — 3 weeks

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 0

19A. DATE OF OPERATION: 1-26-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Resection of Gang-Renous Small Bowel
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 1-25 1967 to 2-21-1967, that (I) (we) last saw the deceased alive on 2-21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: James A. Quinlan Jr — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-21-67
23C. PHYSICIAN'S NAME (Type): JAMES A. QUINLAN JR M.D.
23D. ADDRESS: Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/23/67
24C. NAME of CEMETERY or CREMATORY: Old Har Sinai
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Farbman
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., 6010 Reist., Rd. — ADDRESS

VS 150-REV. 1/1/65 1967 0 0 0 1 9 2 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1919 Registered No. 67 1919

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): REBECCA CAPLAN

2. DATE AND HOUR OF DEATH: 2-23-67 4:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY: 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE D. STREET ADDRESS (If rural, give location): 5014 - PEMBRIDGE AVE

5. SEX: F 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED 8. DATE OF BIRTH: 3-31-82 9. AGE (In years last birthday): 84 If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY: At Home 11. BIRTHPLACE (State or foreign country): Lithuania 12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: Yesrail Levin 14. MOTHER'S MAIDEN NAME: Shama Esther ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.: No 17. INFORMANT: Mr. Milton Caplan, 5014 Pembridge Avenue ADDRESS

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I (A) DUE TO: Myocardial Infarct — 3, 24 hrs

(B) DUE TO:

(C):

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Ft Humerus — 14 days

CERTIFICATION APPROVED BY: [redacted] CHIEF OR ASST. MEDICAL EXAMINER. 2-27-67

19A. DATE OF OPERATION: 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5014 - PEMBRIDGE AVE

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-7-67 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒ 21F. HOW DID INJURY OCCUR? ? PT SLIPPED ON RUG

22. I certify that (I) (this hospital) attended the deceased from 2-22 19 67 to 2-23 19 67 that (I) (we) last saw the deceased alive on 2-23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. Gordon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 2-23-67

23C. PHYSICIAN'S NAME (Type): Dr. C. Gordon M.D. 23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2/24/67 24C. NAME of CEMETERY or CREMATORY: Bnai Israel 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967 25B. NAME OF REGISTRAR: Robert E. Tarbyns 25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., 6010 Reist., Rd. ADDRESS

VS 150-REV. 1/1/65 N854129670001926

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Body released by Medical Examiner

S-140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1920 Registered No. 67 1920

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rose Sabel

2. DATE AND HOUR OF DEATH: February 23, 1967 1 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 5829 ~~Dress~~ Western Run Drive apt. B.

2-20

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF DATH: Oct 27, 1894

9. AGE (In years last birthday): 72

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Secretary

11. BIRTHPLACE (State or foreign country): Montgomery, Ala.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Solomon Sabel

14. MOTHER'S MAIDEN NAME: Rose ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-16-5224

17. INFORMANT: Miss Lena Sabel ADDRESS: 5829 Western Run Drive

MEDICAL CERTIFICATION

18. 331 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CEREBROVASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: few minutes

DUE TO

(B) arteriosclerosis, generalized

DUE TO

(C) Myocardial Infarction 1964

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 19 64 to February 19 67, that (I) (we) last saw the deceased alive on 19 January 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Abraham Genecin M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 24 February 1967

23C. PHYSICIAN'S NAME (Type): ABRAHAM GENECIN M.D.

23D. ADDRESS: 611 PARK AVE

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: Feb 24/67

24C. NAME of CEMETERY or CREMATORY: Kahl-Montgomery

24D. LOCATION (City, town, or county) (State): Montgomery, Alabama

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fanbaum

25C. FUNERAL DIRECTOR: Sol Lemmon & Bro Inc

ADDRESS: 6010 Reisterstown Road

VS 150-REV. 1/1/65

1967 0 0 0 1 9 2 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1921 | Registered No. 67-1921

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Evans Rich

2. DATE AND HOUR OF DEATH: 2/23/67 1 22 47 30 AM. 7:30 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore - Edgemere 53-00

D. STREET ADDRESS (If rural, give location): 7419 North Point Road

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: March 5, 1900

9. AGE (In years last birthday): 66

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian Retired

10B. KIND OF BUSINESS OR INDUSTRY: Ft. Howard School

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John P. Rich

14. MOTHER'S MAIDEN NAME: Fannie Poston

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 250-22-4832

17. INFORMANT: Wife, Fannie Rich, #4,a,b,c,d. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Klebsiella Pneumonia — 1 wk

DUE TO

(B) Chronic Glomerulonephritis

DUE TO

Myopathy - Aortic Insufficiency

(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/18 19 67 to 2/23 19 67, that (I) (we) last saw the deceased alive on 2/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard Maffezzoli M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/23/66

23C. PHYSICIAN'S NAME (Type): Richard Maffezzoli M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/26/67

24C. NAME of CEMETERY or CREMATORY: Mount Nebo Cemetery

24D. LOCATION (City, town, or county) (State): Berkeley Springs, W. Va.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR: John J. Duda, Dundalk, Md. 21222 ADDRESS

VS 150-REV. 1/1/65

1 9 6 7 0 0 0 1 9 2 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1922 Registered No. 67 1922

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STANLEY, ELY

2. DATE AND HOUR OF DEATH: 2/18/67 5:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp. 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balt.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt. 13-01
D. STREET ADDRESS (If rural, give location): 2401 Eutaw Pl.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): —
8. DATE OF BIRTH: 11/10/06
9. AGE (In years last birthday): 60
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bob Stanley
14. MOTHER'S MAIDEN NAME: Lena Butch

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: chart record
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute MI — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rheumatoid arthritis

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/28/67 19 to 2/18 19 67, that (I) (we) last saw the deceased alive on 2/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. McCaffry M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/18/67
23C. PHYSICIAN'S NAME (Type): James Feldner M.D.
23D. ADDRESS: Md General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-24-67
24C. NAME of CEMETERY or CREMATORY: Sacred Heart
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Sarbaugh
25C. FUNERAL DIRECTOR: Walter Dabrowski
ADDRESS: 1005 Dundalk Ave.

VS 150-REV. 1/1/65

67 0 0 1 9 2 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1923 Registered No. 67 1923

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY M. GORMAN

2. DATE AND HOUR OF DEATH: 2-26-67 2.45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 28-41

D. STREET ADDRESS (If rural, give location): 5522 LIBERTY HEIGHTS AVE

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED

8. DATE OF BIRTH: 1-12-92

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Payroll Clerk

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): IRELAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Gorman

14. MOTHER'S MAIDEN NAME: Bridget O'Day

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 401-03-3657

17. INFORMANT: Rosemary McCann — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

331 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Possible C.V.A.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-23 19 67 to 2-26 19 67, that (I) (we) last saw the deceased alive on 2-26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lucas C. Vidhyaphum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-26-67

23C. PHYSICIAN'S NAME (Type): LUCAS C. VIDHYAPHUM M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3-1-67.

24C. NAME of CEMETERY or CREMATORY: Calvary Cemetery

24D. LOCATION (City, town, or county) (State): Louisville, Kentucky.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Lahey M.D.

25C. FUNERAL DIRECTOR: Ellsworth Armacost — ADDRESS: 4600 Liberty Hights

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-51-37
IW

K-146

BIRTH NO. 67 1924

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1924

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): KESSLER, EDWARD JOSEPH

2. DATE AND HOUR OF DEATH: 2-23-1967 7:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-05
D. STREET ADDRESS (If rural, give location): 2224 CHRISTIAN STREET - 21224

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6/14/89
9. AGE (In years last birthday): 77
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brush Comber
10B. KIND OF BUSINESS OR INDUSTRY: Brush Co.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH Kessler
14. MOTHER'S MAIDEN NAME: EMMA Van.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 493X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia — 3 days

DUE TO

(B) Pneumonia + — 1 mo

DUE TO

(C) abscesses of buttocks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia + cerebral vascular disease

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-16 1967 to 2-23 1967, that (I) (we) last saw the deceased alive on 2-23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. C. Cameron M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-23-67
23C. PHYSICIAN'S NAME (Type): E. C. CAMERON M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Feb. 25, 1967
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: G. Truman Schwab
ADDRESS: 3512 Frederick Ave, Balto. Md.

VS 150-REV. 1/4/65

0 0 1 9 3 1

L-516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1925 Registered No. 67 1925

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAE MRS. ETTA M. LAMBERT

2. DATE AND HOUR OF DEATH: FEB. 23, 1967 5:52 P.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

35 CHURCH HOME AND HOSPITAL
100 NORTH BROADWAY, BALTO.31, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
7924 UNDERHILL ROAD Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE, MARYLAND 21206 53-00
D. STREET ADDRESS (If rural, give location)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	WHITE	widowed	10/6/1893	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	MARYLAND, Baltimore	

13. FATHER'S NAME: JOSEPH HOLLAR

14. MOTHER'S MAIDEN NAME: EDITH EHRHARDT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: 1947 Sunberry Rd. 22
Bernadine Schnepf, neice,

MEDICAL CERTIFICATION

18. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Atrial Fibrillation
DUE TO
(B) Arteriosclerotic HD.
DUE TO
(C) Pulmonary Edema

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—		Yes	Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ ~~CAUSE OF DEATH~~ (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-2 19 67 to 2-23 19 67 that (I) (we) last saw the deceased alive on 2-23-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: asterito M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-24-67

23C. PHYSICIAN'S NAME (Type): DR. G. BAUMGARDNER M.D.

23D. ADDRESS: CH & H

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/27/67	Oak Lawn Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 2601 E. Madison St.

VS 150-REV. 1/1/65

1967 0001932

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-660

67 1926

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 1926

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Walter Brewer

2. DATE AND HOUR PRONOUNCED DEAD: 2/24/67 4:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED

FULL NAME OF HOSPITAL OR INSTITUTION: Union Memorial Hospital

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 3-3-67

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

24-04

D. STREET ADDRESS (If rural, give location): 603 E. Randall St.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Aug. 23, 1908

9. AGE (In years last birthday): 58

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10B. KIND OF BUSINESS OR INDUSTRY: Life Like Products

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Brewer

14. MOTHER'S MAIDEN NAME: Anna Wolf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 142-14-6555

17. INFORMANT: Family-

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E915.3

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): factory

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1600 Union Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2 24 67 4:20a.m.

21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? explosion of boiler

13-08

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: ~~12/24/67~~ 2-24-67

23A. BURIAL CREMATION, REMOVAL (Specify): ~~2-27-67~~ Cremation

23B. DATE: 2-27-67

23C. NAME of CEMETERY or CREMATORY: Louden Park Cemetery

23D. LOCATION (City, town, or county): Baltimore (State): Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: McCully

ADDRESS: 130 E. Fort Ave. Balto. 30

VS 151-REV. 1/1/65

N869.2 9 6 7 0 0 0 1 9 3 3

Letter from M.E.'s office 3-3-67 M.H.

48-68-48
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1927 Registered No. 67 1927

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DANIEL W. GROOM

2. DATE AND HOUR OF DEATH: 2-21-67 5:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-11

D. STREET ADDRESS (If rural, give location): 3328 FLEET STREET - 21224

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	6/20/06	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Watchman	Balto. City	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Conrad Groom

14. MOTHER'S MAIDEN NAME: Anna Spann

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 ADDRESS

MEDICAL CERTIFICATION

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

DUE TO

(B) ARTERIOSCLEROSIS AND

DUE TO

(C) HYPERTENSION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2-13-1 19 67 to 2-21 19 67, that (I) (~~we~~) last saw the deceased alive on 2-21 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Carlos R. Hamilton Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-21-67

23C. PHYSICIAN'S NAME (Type): CARLOS R. HAMILTON, JR. M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2-25-67	Oak Lawn Cemetery	7225 Eastern Blvd. Ba. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 27 1967	Robert E. Fairbanks	Charles S. Geiler	301 S. Conkling St. Balto., 21224, Md.

VS 150-REV. 1/1/65

B-6251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1928 Registered No. 67 1928

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA BRZNCWICZ

2. DATE AND HOUR OF DEATH: 2/25/1967 11 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2123 EASTERN AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2123 EASTERN AVE

1-004

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: JUNE 1881
9. AGE (In years last birthday): 86
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH KRYMSKI
14. MOTHER'S MAIDEN NAME: RYNIEWICZ

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: STANLEY BRZNCWICZ
ADDRESS: 2123 EASTERN AVE

MEDICAL CERTIFICATION

18. 527.1

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Insufficiency — 2 yrs.
DUE TO
(B) Chronic Emphysema — 10 yrs.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 19 25 to 2/25 19 67, that (I) (we) last saw the deceased alive on Feb. 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John V. Sczerbicki M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-27-67
23C. PHYSICIAN'S NAME (Type): John V. SCZERBICKI M.D.
23D. ADDRESS: 1802 Eastern Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 3/1/67
24C. NAME of CEMETERY or CREMATORY: HOLY ROSARY CEMETERY
24D. LOCATION (City, town, or county) (State): BALTIMORE MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Fairbanks
25C. FUNERAL DIRECTOR: JOHN M. WEBER & SONS INC.
ADDRESS: 401 S. CHESTER ST.

VS 150-REV. 1/1/65

1967 000 1935

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-5001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1929 Registered No. 67 1929

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GUNN, CLARA B.

2. DATE AND HOUR OF DEATH: 2-23-67 | 6 20 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 4604 LEEDS AVE.

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 4-8-88
9. AGE (In years last birthday): 78
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Wheat
14. MOTHER'S MAIDEN NAME: Clara — —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Sarah Jones — ADDRESS: 4604 Leeds Ave.

MEDICAL CERTIFICATION

18. I 420.1 & 260 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) POSSIBLE Myocardial Infarction

DUE TO

(B) ARTERIOSCLEROTIC HEART DISEASE

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FEB 7, 19 67 to FEB 23 19 67, that (I) (we) last saw the deceased alive on FEB 23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Kil Kim M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/23/67
23C. PHYSICIAN'S NAME (Type): YOUNG KIL KIM M.D.
23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Fashburn
25C. FUNERAL DIRECTOR: Hubbard Funeral Home — ADDRESS: 410 Wilkens Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-335

67 1930

BIRTH NO. 63-27151

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1930

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Steadman Craig W

2. DATE AND HOUR OF DEATH: 2-24-67 | 7.12 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: Balto Co.
2115 Meadow view Drive
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 2115 Meadow view Drive

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Child
8. DATE OF BIRTH: 9-21-63
9. AGE (In years last birthday): 3 yrs.
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Steadman.
14. MOTHER'S MAIDEN NAME: Evelyn Failinger

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Pneumonia (Streptococcus)

(B) DUE TO:

(C):

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/14/67 1967 to 2/24 1967, that (I) (we) last saw the deceased alive on 2/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C K Boe M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/24/67
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS: M.D. Bon Secours Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/67
24C. NAME of CEMETERY or CREMATORY: Lorraine Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Talbert M.D.
25C. FUNERAL DIRECTOR: HUBBARD FUNERAL HOME
ADDRESS: 4107 Wilkens Ave.

21229

VS 150-REV. 1/1/65

1967 0001937

M-200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1931 Registered No. 67 1931

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph E. McGee

2. DATE AND HOUR OF DEATH: February 23, 1967 9:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-52
D. STREET ADDRESS (If rural, give location): 2803 Georgetown Road 21230

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 4/13/90
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance-Retired
10B. KIND OF BUSINESS OR INDUSTRY: Md. Biscuit Co.
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: McGee
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mary E. Poling, 1733 Wilmington Ave. ADDRESS: Balto., Md. 21230

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarction — 2 hours
DUE TO
(B) Hypertensive Cardio Vascular Disease — 3 years
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/18 1965 to 2/23 1967, that (I) ~~(we)~~ last saw the deceased alive on 2/21 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: John P. Urlock Jr M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/24/67
23C. PHYSICIAN'S NAME (Type): John P. Urlock, Jr. M.D.
23D. ADDRESS: 1227 Washington Blvd., Balto., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/27/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Stakemann
25C. FUNERAL DIRECTOR: Howard H. Hubbard Funeral Home ADDRESS: 4107 Wilkens Ave., Balto., Md. 21229

VS 150-REV. 1/1965

C-5161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1932 Registered No. 67 1932

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (JAMES THOMAS CHAMBERS) Chambers James

2. DATE AND HOUR OF DEATH 2/23/67 8.55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

CERTIFICATE AMENDED 3-21-67

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY 706
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218
D. STREET ADDRESS (If rural, give location) 3007 Alameda Blvd. # 18

5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed 8. DATE OF BIRTH 1/16/1878 9. AGE (In years last birthday) 89 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing Salesman- 10B. KIND OF BUSINESS OR INDUSTRY Retired-The Hub 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ? Chambers 14. MOTHER'S MAIDEN NAME Not Known

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-09-2447

17. INFORMANT JAMES T. CHISHOLM, Bird River Rd. ADDRESS Middle River, Md. 21220

MEDICAL CERTIFICATION

18. 420.0 I 4903.9

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) heart failure,
DUE TO
(B) (1) hip fracture
DUE TO
(C) ASHD, (2) bundle branch block

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Electrolyte imbalance

CERTIFICATION APPROVED BY [signature] CHIEF OR ASST. MEDICAL EXAMINER 2-27-67

19A. DATE OF OPERATION 3/8/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ ☑ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Backyard 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3007 Alameda Blvd + 18th

21D. TIME OF INJURY (APROX.) (Month) (Day) (Year) (Hour) 2/6/67 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☑ 21F. HOW DID INJURY OCCUR? Fell in backyard

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Ruebel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED 2/23/67

23C. PHYSICIAN'S NAME (Type) H. Irwin Ruebel M.D. 23D. ADDRESS Sinai Hospital Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE Feb. 27. 1967 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 27 1967 25B. NAME OF REGISTRAR [signature] 25C. FUNERAL DIRECTOR HENRY SANDER & SONS. INC. ADDRESS Baltimore Md.

VS 150-REV. 1/1/65

N 820.0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Driver's License from State of Md. dated
12-10-1937 and V.S. 153 3-21-67 M.H.

N-470

67 1933

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1933

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Ross Nowlin

2. DATE AND HOUR OF DEATH: 2/25/67 18⁰⁰ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 9.9.C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 52-00
D. STREET ADDRESS (If rural, give location): 229 Bishop Ave.

5. SEX: M
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 7/28/1910
9. AGE (In years last birthday): 56
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Nolan
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joan Adam — ADDRESS: 229 Bishop Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

153.1 + 1 260X

(A) ?

DUE TO

(B) Intestional Obstruction — 1 mo

DUE TO

(C) CA. of Splenic flexor — 2 mo?

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Diabetes Mellitus, ASCVD

19A. DATE OF OPERATION: 3/5/67, 3/14/67, 3/19/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CA of Bowel
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/5/67 19 to 2/25/67 19, that (I) (we) last saw the deceased alive on 2/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M.J. Rokoff, M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/25/67
23C. PHYSICIAN'S NAME (Type): ROKOFF, M.O.
23D. ADDRESS: Mercy Hosp

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/2/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): Brooklyn Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Stallings
25C. FUNERAL DIRECTOR: Charles A. Rice
ADDRESS: 661 W Baltimore St

VS 150-REV. 1/1/65

1967 0001210

B-400

BIRTH NO. 67 1934

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1934

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Bertha S. Bell

2. DATE AND HOUR OF DEATH: February 25, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 614 S. Fremont Ave

5. SEX: F.
6. RACE: C.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3/15/02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Scott Noland
14. MOTHER'S MAIDEN NAME: Agnes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rev. William A. Bell
ADDRESS: 614 S. Fremont Ave

MEDICAL CERTIFICATION

18. 578X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) SEPTICEMIA — 5 DAYS
DUE TO
(B) INTESTINAL OBSTRUCTION
DUE TO
(C) RUPTURED ILEUM & GANGRENE OF TRANSVERSE COLON

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/20/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: INTESTINAL OBSTRUCTION
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/18/67 19 to 2/25/67 19, that (I) (we) last saw the deceased alive on 2/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. Welcome M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/27/67
23C. PHYSICIAN'S NAME (Type): H. C. WELCOME M.D.
23D. ADDRESS: 1106 HARLEM BALTO, MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/1/67
24C. NAME of CEMETERY or CREMATORY: Wayman
24D. LOCATION (City, town, or county) (State): Ann Arundle Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Charles A. Rice
ADDRESS: 661 W. Barre St.

VS 150-REV. 1/1/65

H-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1935 Registered No. 67 1935

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOWARD M. HECK

2. DATE AND HOUR OF DEATH: 2/25/67 | 10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LITTLE SISTERS OF THE POOR, 1200 VALLEY STREET, BALTIMORE, MD. 21202

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 10-01
D. STREET ADDRESS (If rural, give location): 1200 VALLEY STREET

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 12/13/1882
9. AGE (In years last birthday): 84
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): HANOVER, PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HENRY HECK
14. MOTHER'S MAIDEN NAME: ELIZABETH MUMMERT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): YES 8/31/1914 to 6/30/1916
16. SOCIAL SECURITY NO.: 216-14-3159
17. INFORMANT: LITTLE SISTERS OF THE POOR — ADDRESS: 1200 VALLEY STREET, BALTIMORE, MD. 21202

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema

DUE TO

(B) C.S. congestive heart.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1966 to 2.25. 1967, that (I) (we) last saw the deceased alive on 2.25. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Ankudas M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2.27.67
23C. PHYSICIAN'S NAME (Type): STANLEY ANKUDAS M.D.
23D. ADDRESS: 1101 MAIDEN CHOICE LANE BALT., MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-1-1967
24C. NAME of CEMETERY or CREMATORY: Mt. Zion Methodist Episcopal
24D. LOCATION (City, town, or county) (State): Harford County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Lilly & Zeiler Inc. ADDRESS: 1901-07 Eastern Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1

D-300

67 1936

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1936

1. NAME OF DECEASED (Type or Print): Richard W. Doda

2. DATE AND HOUR PRONOUNCED DEAD: 2/20/67 7:46 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Overlea 53-00

D. STREET ADDRESS (If rural, give location): 10 Leslie Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9-17-27

9. AGE (In years last birthday): 39

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Officer

10B. KIND OF BUSINESS OR INDUSTRY: Balto. City Police

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alexander Doda

14. MOTHER'S MAIDEN NAME: Anna Kuczak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes

(If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 216-24-2656

17. INFORMANT: Mildred Doda

ADDRESS: 10 Leslie Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH

I. 1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 2/20/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2/24/67

23C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

24B. NAME OF REGISTRAR: Robert E. Fairbanks

24C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home, Inc.

ADDRESS: 1501 E. Fort Avenue

VS 151-REV. 1/1/65

1967 0001943

C-4210

BIRTH NO. 67 1937

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1937

1. NAME OF DECEASED (Type or Print): CALOS, VASILIKI (Vasiliki)

2. DATE AND HOUR OF DEATH: 2-22-67 | 3:25AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO., 29, MD.

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: A.A. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): PASADENA 52-00

D. STREET ADDRESS (If rural, give location): 235 MILLARD DR.

5. SEX: FEMALE

6. RACE: CAUCASION

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 01-06-92

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY? Greece

13. FATHER'S NAME: George Diacoumakos

14. MOTHER'S MAIDEN NAME: Elaine Vasilakos

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: ST. AGNES RECORDS: WILKENS & CATON AVES

ADDRESS:

MEDICAL CERTIFICATION

18. 420.1 + 1260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute myocardial infarction

DUE TO

(B) Acid and diabetes

DUE TO

(C) Malaise

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2/22 1967 to 2/22 1967, that (I) (~~we~~) last saw the deceased alive on 2/22 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (did ~~not~~) view the body after death.

23A. SIGNATURE: John H. Shaw M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/22/67

23C. PHYSICIAN'S NAME (Type): John H. Shaw M.D.

23D. ADDRESS: 5800 Edmondson Ave. Balt. 27, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/25/67

24C. NAME of CEMETERY or ~~CREMATORY~~: Greek Orthodox Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fabiano

25C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home, Inc.

ADDRESS: 1504 E. Fort Avenue

1967 000 1944

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-20D

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1938 Registered No. 67 1938

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Carrie Loose

2. DATE AND HOUR OF DEATH: 2-20-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 24-01
D. STREET ADDRESS (If rural, give location): 1359 Hull St

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 2/2/1892
9. AGE (In years last birthday): 75 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Confectionary Store owner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Un Known
14. MOTHER'S MAIDEN NAME: Un Known
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-34-2141
17. INFORMANT: Mrs. Audry Kane — ADDRESS: 1359 Hull St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1+ 260X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — 1/2 hour
DUE TO
(B) Arterio sclerotic Heart Disease — 5 years
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — 3 years

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/15 1962 to 2/20 1967, that (I) (we) last saw the deceased alive on 2/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harry Deibel M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/23/67
23C. PHYSICIAN'S NAME (Type): Harry Deibel M.D.
23D. ADDRESS: 1236 Hanover St. Balto 21230

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/24/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Farbman
25C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home, Inc. — ADDRESS: 1504 E. Fort Avenue

VS 150-REV. 1/1/65

1967000195

J-525

BIRTH NO. 67 1939

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1939

1. NAME OF DECEASED (Type or Print): EVA JOHNSON

2. DATE AND HOUR OF DEATH: 2-25-67 | 1.35 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: A.A. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): MARLEY CREEK 52-00

D. STREET ADDRESS (If rural, give location): 7355 FURNACE ROAD

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 9-9-00

9. AGE (In years last birthday): 66

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ?

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?? Unknown

14. MOTHER'S MAIDEN NAME: ? Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Lena Wallace

ADDRESS: 1120 Abbott St.

MEDICAL CERTIFICATION

1B. 053.4 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Sepsis

(B) DUE TO:

(C):

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-15 1967 to 2-25 1967, that (I) (we) last saw the deceased alive on 2/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W Wilson M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/25/67

23C. PHYSICIAN'S NAME (Type): W Stan Wilson M.D.

23D. ADDRESS: JWH.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-27-67

24C. NAME of CEMETERY or CREMATORY: National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Raydolph J. Collick

ADDRESS: 2431 E. Oliver St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K 52

BIRTH NO. 67 1940

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 7977 67 1940

1. NAME OF DECEASED (Type or Print): KING, Lucy Ann

2. DATE AND HOUR OF DEATH: 2/22/67 9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore B. COUNTY: 2229
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 30-01
D. STREET ADDRESS (If rural, give location): 26 N. Kossuth St.

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 12/17/95
9. AGE (In years last birthday): 71
(If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRED McCLAIN
14. MOTHER'S MAIDEN NAME: Mary Russell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: VALERIE BURKS
ADDRESS: W15-7187

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) pneumonia
DUE TO
(B)
DUE TO
(C) chronic lung condition

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

493X

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19 ____ to _____ 19 ____, that (I) (we) last saw the deceased alive on 2/22/67 19 ____ and that in (my) (our) opinion death accurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chang Kue Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/22/67
23C. PHYSICIAN'S NAME (Type): CHANG KUE KIM M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 2-25-67
24C. NAME of CEMETERY or CREMATORY: First Baptist Church
24D. LOCATION (City, town, or county) (State): Victoria, Virginia

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Tarkey M.D.
25C. FUNERAL DIRECTOR: Randolph J. Collick
ADDRESS: 2431 E. Oliver St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1967 00 1 97

1.
5-514

BIRTH NO. 67 1941

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1941

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Adolph Schneebeli

2. DATE AND HOUR PRONOUNCED DEAD: 2/21/67 12:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Wicomico
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salisbury 72-00
D. STREET ADDRESS (If rural, give location): Shavox Rd. R.D.#3

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: March 21, 1890
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: 11 Days: 0 Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Switzerland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Heinrich Schneebeli
14. MOTHER'S MAIDEN NAME: Berta Vollenweider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-50-4991
17. INFORMANT: Mrs. Lena Oggier(Niece) ADDRESS: R.D.#3, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
E976X
(A) Gunshot wound of head
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): chicken house
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Shavox Rd. 72-00
21D. TIME OF INJURY (APPROX.) (Month) 2 (Day) 20 (Year) 67 (Hour) 8:30 a.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? shot self

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 2/21/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: Feb. 25, 1967
23C. NAME of CEMETERY or CREMATORY: Wicomico Memorial Park
23D. LOCATION (City, town, or county) (State): Salisbury, Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS:

VS 151-REV. 1/1/65

N856.4 9 6 7 0 0 0 1 9 4 8

48-11-08 JB K-600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1942 Registered No. 67 1942

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RICHARD WILLIAM KERR

2. DATE AND HOUR OF DEATH: 2-24-67 | 6:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): RURAL ESSEX, 53-00
D. STREET ADDRESS (If rural, give location): WILSON PT ROAD-& BEACH DRIVE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED
8. DATE OF BIRTH: 9-1-01
9. AGE (In years last birthday): 65
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MECHANIC
10B. KIND OF BUSINESS OR INDUSTRY: AUTO INDUST.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN KERR
14. MOTHER'S MAIDEN NAME: FLORENCE ADAMS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): WORLD 11
16. SOCIAL SECURITY NO. 076-09-8373
17. INFORMANT: #21224 ADDRESS: RECORDS-BCH-4940 EASTERN AVENUE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 331 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) aspiration pneumonia — 3 weeks.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B)

DUE TO (C) bilateral CVA's — 1 yr.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/15 1966 to 2/24/67 19, that (I) (we) last saw the deceased alive on 2/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Bruce M. Dow M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/24/67
23C. PHYSICIAN'S NAME (Type): BRUCE M. DOW M.D.
23D. ADDRESS: 4940 Eastern Ave. Balto. City Hosps. Baltimore, Md. # 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: Feb 27 1967
24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery
24D. LOCATION (City, town, or county) (State): 5501 Frederick Road Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: The Dippel Bros Inc
ADDRESS: 7110 Belair Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1943 Registered No. 67 1943

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LOUIS BALSTER BAILEY

2. DATE AND HOUR OF DEATH: 2-25-67 | 6:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): H4 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21214 27-02
D. STREET ADDRESS (If rural, give location): 4646 WALTHER BLVD

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 12-31-1893
9. AGE (In years last birthday): 73
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Police
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Police Dept.
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: JOHN BAILEY
14. MOTHER'S MAIDEN NAME: CAROLINE HERMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-36-8618
17. INFORMANT: Mrs. Ruth E. Bailey
ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL THROMBOSIS — 24 hours

DUE TO

(B)

DUE TO

(C) arteriosclerotic Heart Disease — 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 02-19-67 19 to 02-25 19 67, that (I) (we) last saw the deceased alive on 02-24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 02-25-67
23C. PHYSICIAN'S NAME (Print): DR ZOLTAN ZARDAY M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Entombment
24B. DATE: 3/1/67.
24C. NAME of CEMETERY or CREMATORY: Lorraine Mausoleum
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-620

BIRTH NO. 67 1944

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1944

1. NAME OF DECEASED (Type or Print): Margaret A. Cherrix

2. DATE AND HOUR PRONOUNCED DEAD: 2/23/67 9:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5416 Lothian Ave. Rd.

27-48

5. SEX: female
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6-22-1916
9. AGE (In years last birthday): 50
If Under 1 Yr. or Under 24 Hrs.: Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Cornelius Claude Andrews
14. MOTHER'S MAIDEN NAME: Margaret Laura Charnock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-14-4852
17. INFORMANT: Vernon T. Cherrix Sr.
ADDRESS: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E 900.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral injury
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5416 Lothian Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2 22 67 ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? fell down steps

27-48

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 2/24/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 2-27-67
23C. NAME of CEMETERY or CREMATORY: Moreland Memorial
23D. LOCATION (City, town, or county) (State): Balto. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
24B. NAME OF REGISTRAR: Robert E. Fankenna
24C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto., Md.

VS 151-REV. 1/1/65

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1945 Registered No. 67 1945

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PROBST, CAROLINE

2. DATE AND HOUR OF DEATH: 2-25-67 | 8 15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: ~~Baltimore~~

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-09

D. STREET ADDRESS (If rural, give location): 1510 Pentridge Rd. (21212)

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12-25-83

9. AGE (In years last birthday): 83

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~None~~ SALES

10B. KIND OF BUSINESS OR INDUSTRY: BRAGER DEPT. STORE

11. BIRTHPLACE (State or foreign country): BALTIMORE MARYLAND

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: UN KNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 219-16-4486

17. INFORMANT: MRS. LEONE BLAINE

ADDRESS: 1510 Pentridge Rd. Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

(A) DUE TO: Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

(B) DUE TO:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-5 1967 to 2-25 1967, that (I) (we) last saw the deceased alive on 2-25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John R. Vaughn Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-25-67

23C. PHYSICIAN'S NAME (Type): JOHN R. VAUGHAN MD. M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/28/1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fogleman

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Baltimore 12, Md.

VS 150-REV. 1/1/65

1967 B 0 0 1 2 5 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300

BIRTH NO. 67 1946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1946

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARIE G. WHITE

2. DATE AND HOUR OF DEATH: 2-24-67 | 6:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL, BALTO., MD. 21201

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: 21218
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 09-01
D. STREET ADDRESS (If rural, give location): 3955 GREENMOUNT AVE.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced (specify))	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	WIDOWED	8/21/94	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SELF EMPLOYED	ADVERTISING BUSINESS	BALTIMORE, MD.	U.S.A.

13. FATHER'S NAME: EDWARD B. McDERMOTT

14. MOTHER'S MAIDEN NAME: MINNIE MYERS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-26-1624

17. INFORMANT (Name): EDWARD D. McDERMOTT (Son) ADDRESS: 325 E. UNIVERSITY PKWY.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 175.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA of (L) OVARY

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/30 1967 to 2/24 1967, that (I) (we) last saw the deceased alive on 2/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/27/67

23C. PHYSICIAN'S NAME (Type): RONALD GOLDNER M.D.

23D. ADDRESS: [signature]

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/27/1967	New Cathedral	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

19670001953

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1947 Registered No. 67 1947

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Marion Hall Meekins

2. DATE AND HOUR OF DEATH: Feb.23,1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gould Convalesarium

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towson 53-00
D. STREET ADDRESS (If rural, give location): 8909 Waltham Woods Road

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 9-4-1892
9. AGE (In years last birthday): 74
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cabinet Maker
10B. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John E. Meekins
14. MOTHER'S MAIDEN NAME: Laura Phillips

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-03-1690
17. INFORMANT: M.Hall Meekins Jr. ADDRESS: 4830 Greencrest Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 177X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Prostate with metastases — 15 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from Nov. 1965 to Feb. 1967, that (I) ~~(we)~~ last saw the deceased alive on Feb. 10 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Wm. H. Kammer Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/24/67
23C. PHYSICIAN'S NAME (Type): William H. Kammer M.D.
23D. ADDRESS: 6011 York Rd., Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-27-67
24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Memorial
24D. LOCATION (City, town, or county) (State): Timonium Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Tarbert M.D.
25C. FUNERAL DIRECTOR: H.W.Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65 1967 0 0 0 1 9 5 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1948 Registered No. 67 1948

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Louis E. Uhl

2. DATE AND HOUR OF DEATH: 2-26-67 6⁰⁰ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1803 Hope St. #2

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2/23/1887
9. AGE (In years last birthday): 80
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pressman (Ret.)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Uhl
14. MOTHER'S MAIDEN NAME: Theresa Digiman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): unk. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217033586
17. INFORMANT: Mrs. Helen E. Uhl-- Same ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONset AND DEATH

(A) 4201 Massive acute MI & CVA — 6 hrs.
DUE TO
(B) Severe Bronchopneumonia
DUE TO
(C) ASCVD — Years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/25 1967 to 2/26 1967, that (I) (we) last saw the deceased alive on 2/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dwight N. Fortin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/26/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Mercy Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/1/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem.,
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: R. Paul E. Fallon
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. ADDRESS: 5305 Harford Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-40D

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1949

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1949

1. NAME OF DECEASED (Type or Print): MARGARET HOLLOWAY

2. DATE AND HOUR OF DEATH: Feb. 25, 1967 8:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA--Union Memorial Hospital

4/49

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-06

D. STREET ADDRESS (If rural, give location): 2402 Hamilton Ave.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 9/10/1903

9. AGE (In years last birthday): 63

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry P. Smith

14. MOTHER'S MAIDEN NAME: Jennie Foster

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. James M. Holloway

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — 420.1 + 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

DUE TO

(B) Arteriosclerotic Cardiovascular Disease — 10 Years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — 3 Years

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from June 12 1964 to Feb 25 1967, that (I) (~~we~~) last saw the deceased alive on June 23 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Adam G. Swiss M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Feb. 27, 1967

23C. PHYSICIAN'S NAME (Type): Dr. Adam G. Swiss M.D.

23D. ADDRESS: 6232 Belair Road, Balto, Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/1/67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fellman

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.-Balto., Md.-14

ADDRESS:

VS 150-REV. 1/1/65

B-230

BIRTH NO. 67 1950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 48705 67 1950

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bockstie, Lawrence George

2. DATE AND HOUR OF DEATH: 2/25/67 11:48 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital 33rd & Calvert Streets. Balto. 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21213

D. STREET ADDRESS (If rural, give location): 2231 Pelham Avenue

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 7/31/99

9. AGE (In years last birthday): 67

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sun Federal Savings & Loan assoc. V.P.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Bockstie

14. MOTHER'S MAIDEN NAME: Unknown Hammann

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-09-0559

17. INFORMANT: Mrs. Hilda Bockstie (wife) ADDRESS: 2231 Pelham avenue Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1) Interstitial pulmonary fibrosis — INTERVAL BETWEEN ONSET AND DEATH: 2) Ca. of lung

DUE TO

3) Chronic congestive failure

DUE TO

4) Repeated pulm. embolism c̄ Myocard. infarction. Repeated pneumonia

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: White At Work ☐ Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 6 1967 to Feb. 25 1967, that (I) (we) last saw the deceased alive on Feb. 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang-Kyun Shin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb. 25, 1967

23C. PHYSICIAN'S NAME (Type): SANG-KYUN SHIN M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

Ingeborg W. Fromm

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/28/67.

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Faber M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS

VS 150-REV. 1/1/65

1967 0 0 1 9 5 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-267

BIRTH NO. 67 1951

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1951

1. NAME OF DECEASED (Type or Print) McCracken Jere S.

2. DATE AND HOUR OF DEATH 2/24/67 4:40 P M.

CERTIFICATE AMENDED 3-6-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT. 21206 27-34
D. STREET ADDRESS (If rural, give location) 3906 FRANKFORD AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	M	10/22/92	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
~~RETIRED~~ Printer	Balto. News American	Pa.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Lorenzo McCracken	? Annie Adams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2 One	172-01-5824	Mrs. Mildred M. McCracken	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Abdominal Aorta

DUE TO

(B) Aneurysm

DUE TO

(C) Acute Bronchopneumonia 2° to aspiration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

451 X

A. Lyalito, M.D.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/24 1967 to 2/24 1967, that (I) (we) last saw the deceased alive on 2/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE C B Wallace M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 2/24/67

23C. PHYSICIAN'S NAME (Type) C. B. WALLACE M.D.

23D. ADDRESS THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/28/67.	Baltimore National Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 27 1967	Robert E. Talbert, M.D.	Leonard J. Ruck, Inc.	Balto. Md. 21214

VS 150-REV. 1/1/65

1267000 1958

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 3-6-67 M.H.

17-155

BIRTH NO. 67 1952

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 1952

1. NAME OF DECEASED (Type or Print): Hoffman, Mrs. Viola

2. DATE AND HOUR OF DEATH: 2-22-67 2.20 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital 827 Linden Ave. Balto., Md. 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Broadway Rd. Lutherville, Md. 21093

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Lutherville Md 21093 Balto Co.

D. STREET ADDRESS (If rural, give location): Broadway Rd. 53-00

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 5-7-88

9. AGE (In years last birthday): 78

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Matthew Brown

14. MOTHER'S MAIDEN NAME: Elizabeth Blouse

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Elizabeth Laird ADDRESS: -Same-

MEDICAL CERTIFICATION

18. 631 X-1 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute renal failure — 13 days

DUE TO

(B) Infectious shock — 13 days

DUE TO

(C) Vaginal hysterectomy

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus — unknown

19A. DATE OF OPERATION: 2-1-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Rectocele, cystocele

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-9- 1967 to 2-22- 1967, that (I) (we) last saw the deceased alive on 2-22- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George N. Agapitos M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2-22-67

23C. PHYSICIAN'S NAME (Type): GEORGE N. AGAPITOS M.D.

23D. ADDRESS: MARYLAND GEN. HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/25/67

24C. NAME of CEMETERY or CREMATORY: Carroll's Chapel

24D. LOCATION (City, town, or county) (State): Balto Co, Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Justin E. Donovan

ADDRESS: 3818 Roland Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-650

BIRTH NO. 67 1953

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1953

CERTIFICATE AMENDED 3-6-67

1. NAME OF DECEASED (Type or Print): ALBERT BROWN	2. DATE AND HOUR PRONOUNCED DEAD: February 23, 1967 1:59 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Sinai Hospital (DOA)	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1308 D. STREET ADDRESS (If rural, give location): 3610 Parkdale Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Sept 7, ~~1925~~ 1926	~~41~~ 40				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Driver	Enterprise Fuel Oil Co	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles E. Brown	Mary J. Montgomery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	2nd W.W. Navy	?	Helen V. Brown	3610 Parkdale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.0

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

DATE SIGNED February 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	2/25/67	Lorraine Park	Windsor Mill Rd, Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 27 1967	Robert E. Farley, M.D.	Austin E. Donovan	3818 Roland Ave

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 1 9 6 0

V.S. 153 3-6-67 M.H.

L-2510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1954 Registered No. 67 1954

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lashine, Philip

2. DATE AND HOUR OF DEATH: 2/23/67 | 8.50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03

D. STREET ADDRESS (If rural, give location): 3305 Cliftmont ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	11-02-04	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (owned newsstand)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): New York city

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lashine

14. MOTHER'S MAIDEN NAME: Anna Levine

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.

17. INFORMANT: Daughter

ADDRESS: 3864 Lyndale ave. Balto.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

DUE TO

(B) ASCVD

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 23 19 67 to Feb. 23 19 67, that (I) (we) last saw the deceased alive on Feb. 23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Kyum Shin — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb. 23, 67

23C. PHYSICIAN'S NAME (Type): DR. SANG KYUM SHIN — J. Rollin Otto M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	Feb. 24, 67	Gardens of Faith	Trumps Mill Rd at Kenwood, Balto.	Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Jack Lewis, Inc. ADDRESS: 2100 Eutaw Place Balto. Md.

VS 150-REV. 1/1/65

1967000196 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1955 Registered No. 67 1955

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Cyrus Field Ricker

2. DATE AND HOUR OF DEATH: 24 Feb 67 | 9 45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fayette Convalescent Home

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Balt 21-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt 21230

D. STREET ADDRESS (If rural, give location): 1215 Scott St

5. SEX: M 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Wid

8. DATE OF BIRTH: 27 Aug 76 9. AGE (In years last birthday): 90

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Ricker

14. MOTHER'S MAIDEN NAME: Villa de Isle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Son R Conley Ricker ADDRESS: Lake Dr Pasadena Md

MEDICAL CERTIFICATION

18. 491X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

(B) DUE TO:

(C):

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD CVA Emphys, Cataracts, Arcuses, Hernias

19A. DATE OF OPERATION: 6

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12 Dec 1967 to 24 Feb 1967, that (I) (we) last saw the deceased alive on 24 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J Hulla M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 24 Feb 67

23C. PHYSICIAN'S NAME (Type): J Hulla M.D.

23D. ADDRESS: 2214 E Fayette St Balt Md 21231

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY: Western

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc. Baltimore, Md. ADDRESS

0 1 9 6 2

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-54-92 1B

BIRTH NO. G-62-1 67 1956

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1956

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Algernon Gross

2. DATE AND HOUR OF DEATH: 2-23-67 | 2 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-03

D. STREET ADDRESS (If rural, give location): 2224 Eutaw Place - #21217

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Separated

8. DATE OF BIRTH: 12-26-11

9. AGE (In years last birthday): 55

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Rebecca

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE, #21224

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 162.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from Jan 22 1967 to Feb 23 1967, that ~~(I)~~ (we) last saw the deceased alive on Feb 22 1967 and that ~~In(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Alex Silverman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Feb. 23, 1967

23C. PHYSICIAN'S NAME (Type): Dr. Alex Silverman M.D.

23D. ADDRESS: BCH-4940 EASTERN AVENUE -BALTIMORE, MD. #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State): Westport (Baltimore) Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Joseph L. Russ

ADDRESS: 2222 W. North Ave. Baltimore, Md.

VS 150-REV. 1/1/65

B7030963

B.2551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1957 Registered No. 67 1957

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BUCHANAN, CLARENCE M

2. DATE AND HOUR OF DEATH: Feb 27, 1967 | 12:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital 601 N. Broadway St. Baltimore, M

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: South Carolina. B. COUNTY: V-37
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Travelers Rest.
D. STREET ADDRESS (If rural, give location): RT 2.

5. SEX: MALE. 6. RACE: White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married. 8. DATE OF BIRTH: Feb 10, 1926. 9. AGE (In years last birthday): 41 yrs. (If Under 1 Yr. Months, Days; If Under 24 Hrs. Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owned gas Station. 10B. KIND OF BUSINESS OR INDUSTRY: Gas Station. 11. BIRTHPLACE (State or foreign country): Greenville, S.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Grover Buchanan 14. MOTHER'S MAIDEN NAME: Laura Bryant.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT: McAfee Funeral Home Greenville, S.C. ADDRESS

MEDICAL CERTIFICATION

18. 237X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: (A) Brain Tumor

INTERVAL BETWEEN ONSET AND DEATH: About 4 months.

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/25/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Brain Tumor 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this~~ hospital) attended the deceased from Feb. 16, 1967 to Feb. 27, 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 27, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C Bhushan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 2/27/67 1 A.M.

23C. PHYSICIAN'S NAME (Type): CHHABI BHUSHAN M.D. 23D. ADDRESS: The Johns Hopkins Hospital 601 N. Broadway St., Baltimore 5, Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 3/1/67 24C. NAME of CEMETERY or CREMATORY: Grand View 24D. LOCATION (City, town, or county) (State): Greenville Co., S.C.

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967 25B. NAME OF REGISTRAR: [illegible] 25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc. ADDRESS: 1217 St. Paul St. Baltimore, Md. 2120

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-4501

THE BODY OF HOWARD ALLEN WAS RELEASED ON APPROVAL TO THE JOHNS HOPKINS HOSPITAL BY DR. CORIGAN, MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1958

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 1958

1. NAME OF DECEASED (Type or Print): Allen, Howard

2. DATE AND HOUR OF DEATH: 2/25/67, 12 50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): COCKEYSVILLE 21030 53-00

D. STREET ADDRESS (If rural, give location): 219 WARREN RD.

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-21-05

9. AGE (In years last birthday): 61

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto- Mechanic

10B. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (State or foreign country): Cockeysville, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD ALLEN

14. MOTHER'S MAIDEN NAME: ELLA GREGORY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-10-5501

17. INFORMANT: Mary Lee Howard, Same as # 4 ADDRESS

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E 904.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Emboli — 2 weeks

DUE TO

(B) Fractured Hip — ~3 weeks

DUE TO

(C) Pneumonia — 2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Old CVA

CERTIFICATION APPROVED BY: [signature] M.D. CHIEF OR ASST. MEDICAL EXAMINER. 2/27/67

19A. DATE OF OPERATION: 2-6-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: FRACTURED HIP

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner): X

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 219 WARREN RD. COCKEYSVILLE, MD. 53 00

21D. TIME OF INJURY (APROX.) (Month) (Day) (Year) (Hour): 1-29-67

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR? FT. FELL

22. I certify that (I) (this hospital) attended the deceased from 2/5 1967 to 2/25 1967, that (I) (we) last saw the deceased alive on 2/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: SW Spaulding M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/25/67

23C. PHYSICIAN'S NAME (Type): SW. Spaulding M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. 26, 1967

24C. NAME of CEMETERY or CREMATORY: Prospect Hill Cemetery

24D. LOCATION (City, town, or county) (State): Towson, Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Fontana

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, ADDRESS: 1050 York Road Towson, Md. 21204

VS 150-REV. 1/1/65

N 520.2 8 7 8 0 1 9 6 8

48-72-25 ED W 452

BIRTH NO. 67 1959

M.E. CASE NO. 48 7225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1959

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Rosa Williams

2. DATE AND HOUR OF DEATH: 2/23/67 18:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-02

D. STREET ADDRESS (If rural, give location): 808 St. Paul St.

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~Mrd~~ widowed

8. DATE OF BIRTH: 7/13/92

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Durham N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Tom Mordicai

14. MOTHER'S MAIDEN NAME: Isabel Manger

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 164-03-0214-A

17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md.

ADDRESS #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
18a. 331X & 260X	(A) possible gram (-) sepsis	6 hrs
	DUE TO (B) urinary tract infection	? 4 days
	DUE TO (C) Multiple CVA's	1 yr.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: goitre ; diabetes mellitus

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/17/67 19 67 to 2/23 19 67, that (I) (we) last saw the deceased alive on 2/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Silver M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/23/67

23C. PHYSICIAN'S NAME (Type): Ann Silver M.D.

23D. ADDRESS: 4940 Eastern Ave. Baltimore, Md. Balt. City Hosp's # 21224

24A. BURIAL CREMATION, REMOVAL (Specify): burial

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY: Mt Calvary

24D. LOCATION (City, town, or county) (State): A. A. County Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967

25B. NAME OF REGISTRAR: Robert E. Tydings

25C. FUNERAL DIRECTOR: Joseph E. Hooks Jr.

ADDRESS: 1304 N. Central Ave

VS 150-REV. 1/1/65

48-72-06 DH

F 432 67 1960

BIRTH NO. 67-03351

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1960

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby boy Foltz, (Phyllis)

2. DATE AND HOUR OF DEATH: 2/17/67 1425 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Baltimore City Hospital
(If not in hospital or institution, give street address or location): 4940 Eastern Avenue Baltimore, Maryland #21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 1509 Foltz Ave #21220

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, ~~DIVORCED~~ (specify): NEVER MARRIED
8. DATE OF BIRTH: 2/17/67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 10 Min.: 40

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Foltz
14. MOTHER'S MAIDEN NAME: Phyllis Shipley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: BCH
ADDRESS: 4940 Eastern Avenue Baltimore, Maryland #21224
RECORDS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 776X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity — 10 40/60 hrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/17 1967 to 2/17 1967, that (I) (we) last saw the deceased alive on 2/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Am Overbach M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/17/67
23C. PHYSICIAN'S NAME (Type): Am Overbach M.D.
23D. ADDRESS: 4940 Eastern Avenue Baltimore, Md. #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 2-21-67
24C. NAME of CEMETERY or CREMATORY: Baltimore City Hospitals
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Ralph E. Falkenne
25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL
ADDRESS:

VS 150-REV. 1/1/65

M-622

BIRTH NO. 67-02651 67 1961

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1961 4

1. NAME OF DECEASED (Type or Print): Baby Girl Morekas

2. DATE AND HOUR OF DEATH: FEB-12-67 | 3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 MD. GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21212 53-00
D. STREET ADDRESS (If rural, give location): 6605 Loch Hill Rd.

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): —
8. DATE OF BIRTH: 2-12-67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: Hours: 1 Min.: 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sam Morekas
14. MOTHER'S MAIDEN NAME: Mary H. Poulos

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mother
ADDRESS: 6605 Loch Hill Rd. Baltimore, 21212

MEDICAL CERTIFICATION

18. 773.5

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Prematurity
DUE TO
(B) Respiratory distress
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congenital anomaly of Right Kidney (absent of Right Kidney

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2am 2/12 19 67 to 3:30 pm 2/12 19 67, that (I) (we) last saw the deceased alive on 2/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David Forsythe M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/12/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): HOSPITAL DISPOSAL
24B. DATE: 2/24/67
24C. NAME of CEMETERY or CREMATORY: Md. General Hospital
24D. LOCATION (City, town, or county) (State): 827 Linden Ave. 21201

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Robert E. Tolson
25C. FUNERAL DIRECTOR
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-2001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1962
M.E. CASE NO. 67-02958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 19624

1. NAME OF DECEASED (Type or Print): Baby Girl Resh

2. DATE AND HOUR OF DEATH: Feb 15, 1967 | 8:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Md. Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 26-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 21213
D. STREET ADDRESS (If rural, give location): 3633 Raymonn Ave

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): N.B.
8. DATE OF BIRTH: Feb 15, 1967
9. AGE (In years last birthday): —
If Under 1 Yr. Months: — Days: —
If Under 24 Hrs. Hours: 1 Min.: 38

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kyle Winfield Resh
14. MOTHER'S MAIDEN NAME: Phyllis Mae Nusbaum

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father
ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 776X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 15 19 67 to Feb 15 19 67, that (I) (we) last saw the deceased alive on Feb 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Bmch M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/15/67
23C. PHYSICIAN'S NAME (Type): Bernard Dick M.D.
23D. ADDRESS:

24A. BURIAL CREMATION REMOVAL (Specify):
24B. DATE: 2/24/67
24C. NAME of CEMETERY or CREMATORY: Md Gen'l Hospital
24D. LOCATION (City, town, or county) (State): 527 Linden Ave.-Baltimore Md 21201

25A. DATE REC'D BY HEALTH DEPT.: FEB 27 1967
25B. NAME OF REGISTRAR: Rose E. Jackson
25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL
ADDRESS:

VS 150-REV. 1/1/65

K-500

67 1963

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1963

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mary E. Keene

2. DATE AND HOUR OF DEATH: February 21, 1967 | 2:35p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, 1514 Division Street, Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

15-02

D. STREET ADDRESS (If rural, give location): 1601 Bruce Court

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: May 10, 1893

9. AGE (In years last birthday): 72

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-54-0262

17. INFORMANT: Dorothy Cager-Neice - Rt.1, Box344 Severn, Md.

ADDRESS:

MEDICAL CERTIFICATION

18. 420.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Ventricular Fibrillation

DUE TO

(B) ASHD

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 18, 19 67 to February 21, 19 67, that (I) (we) last saw the deceased alive on February 21, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Khaliq M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: February 21, 1967

23C. PHYSICIAN'S NAME (Type): A. Khaliq M.D.

23D. ADDRESS: 1514 Division Street-Baltimore, Maryland (17)

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-28-67

24C. NAME of CEMETERY or CREMATORY: Asbury Meth. Ch. Cem.

24D. LOCATION (City, town, or county) (State): Severna Park Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: Sullivan Funeral Home

ADDRESS: N. Arlington Av

VS 150-REV. 1/1/65

C-652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1964 Registered No. 67 1964

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Augusta Cornish

2. DATE AND HOUR OF DEATH: ~~2/20/67~~ 2/20/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midtown Home, Inc. 808 St. Paul Street 21202

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 16-01
D. STREET ADDRESS (If rural, give location): 1032 N. Arlington Ave

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 1/3/74
9. AGE (In years last birthday): ~~83~~ 93
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-09-5989D
17. INFORMANT: Tunsee Rice ADDRESS: 1006 N. Arlington Ave

MEDICAL CERTIFICATION

1B. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardio-Respiratory Failure
DUE TO Congestive Heart Failure
(B) Hypertensive-Art CVD
DUE TO
(C) Gen. Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 20 1965 to Feb 20 1967, that (I) (we) last saw the deceased alive on Feb 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Willard Appleford M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/21/67
23C. PHYSICIAN'S NAME (Type): WILLARD APPLEFORD M.D.
23D. ADDRESS: 5901 Park Heights Av.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2-28-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Tadman
25C. FUNERAL DIRECTOR: Sullivan Funeral Home 1011-13 ADDRESS: N. Arlington Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-6116

BIRTH NO. 67 1965

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1965

1. NAME OF DECEASED (Type or Print): Margaret ~~Beitl-Triber~~ Beitel Treiber

2. DATE AND HOUR OF DEATH: Feb. 24, 1967 | 3 40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: DC

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Washington V-48

D. STREET ADDRESS (If rural, give location): 4420 Chesapeake St. N.W.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Sep.

8. DATE OF BIRTH: 10/22/96

9. AGE (In years last birthday): 70

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hungary

12. CITIZEN OF WHAT COUNTRY? Hungary

13. FATHER'S NAME: Kardly Beitel

14. MOTHER'S MAIDEN NAME: Margaret Maidl

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Records- US PHS Hospital, Balto, Md. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 491X-1 204.1

(A) Bronchopneumonia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: Days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Congestive Heart Failure, Acute Myelocytic Leukemia

Days / Weeks

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 23 19 67 to Feb. 24 19 67, that (I) (we) last saw the deceased alive on Feb. 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Vermeulen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-24-67

23C. PHYSICIAN'S NAME (Type): Gerald Vermeulen, M.D. M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-27-67

24C. NAME of CEMETERY or CREMATORY: Gate of Heaven Cem.

24D. LOCATION (City, town, or county) (State): Wheaton, Montgomery Co. Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: H. Donald Wolf Wash. DC

ADDRESS: 2222 Wis. Ave

RGB

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-535

BIRTH NO. 67 1966

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1966

1. NAME OF DECEASED (Type or Print): SHENTON, MINA

2. DATE AND HOUR OF DEATH: 2-24-67 | 12:00P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL EMERGENCY ROOM

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE ZONE 21228

D. STREET ADDRESS (If rural, give location): 113 N. SYMINGTON AVE. 53-00

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-25-07

9. AGE (In years last birthday): 60

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Carroll Co - MD

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Howard Shipley

14. MOTHER'S MAIDEN NAME: Ida Belle Easton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-10-4232

17. INFORMANT: ST. AGNES RECORDS - CATON & WILKENS AVE ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute MI

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-24-67 19 to 2-24-67 19, that (I) (we) last saw the deceased alive on FEBRUARY 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] MD M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2-24-67

23C. PHYSICIAN'S NAME (Type): MIGUEL HEREDIA M.D.

23D. ADDRESS: CATON & WILKENS AVE. BALTO MD

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY: Taylorsville ME Church

24D. LOCATION (City, town, or county) (State): Taylorsville MD

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Farley

25C. FUNERAL DIRECTOR: Farley-Cavanaugh 6601 ADDRESS: Frederick Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-645

BIRTH NO. 67 1967

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 269 4 1967

1. NAME OF DECEASED (Type or Print): MERLING, Margaret Bar

2. DATE AND HOUR OF DEATH: 2/23/67 10:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTO Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 411 Delaware Ave

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 4/21/88
9. AGE (In years last birthday): 78
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Brager
14. MOTHER'S MAIDEN NAME: Bertha Kroman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: BERTHA EDER. ADDRESS: 687-8992 686-7974

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A-S Hrt Dis c C.H.F.
DUE TO
(B) Diabetes mell-Tub
DUE TO
(C) Urinary tract Infection

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on 2/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chang Kue Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS: M.D.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/27/67
24C. NAME of CEMETERY or CREMATORY: HOLY REDEEMER
24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan M.D.
25C. FUNERAL DIRECTOR: Connelly J.H.
ADDRESS: 300 Mace

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-64d

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1968 Registered No. 67 1968

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lillie Corley (AKA) LILLIE MAE

2. DATE AND HOUR OF DEATH: 2-23-67 12:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 39 Provident Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 1501

D. STREET ADDRESS (If rural, give location): 1719 N. Carey Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Married	JAN. 1 1907	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas Washington

14. MOTHER'S MAIDEN NAME: Martha Bryant

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alfonzo Corley - Husband ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Acidosis

DUE TO

(C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 22, 19 67 to February 23, 19 67, that (I) (we) last saw the deceased alive on February 23, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A Khaliq M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-24-67

23C. PHYSICIAN'S NAME (Type): Khaliq, M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-28-66

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): Moncks Corner S.C.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Ralph E. Tolbert

25C. FUNERAL DIRECTOR: Cooper Funeral Home

ADDRESS: 512 N. Carrollton Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

S-160

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 1969

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1969

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDNA M. SCHAEFFER

2. DATE AND HOUR PRONOUNCED DEAD: February 24, 1967 7:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Sinai Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 53-00
D. STREET ADDRESS (If rural, give location): 7000 Alden Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Divorced	6/11/1893	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Personnel Mgr.	Arundel Ice Cream	Baltimore Md.	U.S.A.

13. FATHER'S NAME: William E. Pistel

14. MOTHER'S MAIDEN NAME: Barbara Eckstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-10-7570

17. INFORMANT: Mr. Harry Pistel-3721 Valley Hill Dr. ADDRESS: Randallstown, Md.

MEDICAL CERTIFICATION

18. 422.1 I 260 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease associated with diabetes mellitus

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cirrhosis of liver

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: 2-25-67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	2/28/67	London Park	Balto.	Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
FEB 28 1967	[illegible]	Loving Byers & Zolna	728 Liberty Road Randallstown

VS 151-REV. 1/1/65

67 0 0 1 9 6

32-64-65 DH

E-640

BIRTH NO. 67 1970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1970

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Joseph Erlo

2. DATE AND HOUR OF DEATH: Feb. 25, 1967 | 8:30 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 Eastern Ave Baltimore MD 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21-02
D. STREET ADDRESS (If rural, give location): 1409 W. Ostend St. #21223

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3-15-86
9. AGE (In years last birthday): 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: self-employed
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Joseph ERLO
14. MOTHER'S MAIDEN NAME: GARMELA ERLO

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO. 213-34-2143-H
17. INFORMANT: BCH RECORDS: ADDRESS: 4940 Eastern Avenue Baltimore, Maryland #21224

MEDICAL CERTIFICATION

18. 450.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Generalized arteriosclerosis — 8 yrs
DUE TO
(B)
DUE TO
(C) Parkinson's disease — 8 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-3- 1963 to Feb. 25 19 67, that (I) (we) last saw the deceased alive on Feb. 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hisayuki Kowa M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/25/67
23C. PHYSICIAN'S NAME (Type): HISAYUKI KOWA M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. Balto. MD 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/1/67
24C. NAME of CEMETERY or CREMATORY: Meadowridge Cem.
24D. LOCATION (City, town, or county) (State): Washington Blvd. Dorsey Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: John J. Cowan for Inc.
ADDRESS: 901 Hamilton St. Balto Md 21223

VS 150-REV. 1/1/65

1967 0 0 1 9 7 7

J-530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1971 Registered No. 67 1971

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH C. JONDO

2. DATE AND HOUR OF DEATH: 2/25/67 1:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1-01
D. STREET ADDRESS (If rural, give location): 820 S. Curley Street

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 4/3/1897
9. AGE (In years last birthday): 69
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Cooperage
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: PASQUALE JONDO
14. MOTHER'S MAIDEN NAME: MARIE MIRANO

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-05-5870
17. INFORMANT: Mrs. Emma Jondo
ADDRESS: 820 S. Curley St., Baltimore, Md.

MEDICAL CERTIFICATION

1B. 163 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARCINOMA OF THE LUNG — MONTHS

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD WITH OLD MI — YEARS

19A. DATE OF OPERATION: 2/24/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CARCINOMA OF LUNG
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/27 1967 to 2/25 1967, that (I) (we) last saw the deceased alive on 2/25 1967 and that I (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Bruce Gerber, M.D.
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 2/25/67

23C. PHYSICIAN'S NAME (Type): S. BRUCE GERBER M.D.
23D. ADDRESS: 8045 WOODLAWN CT., BALTO., MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/28/67
24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE RECEIVED HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Jackson
25C. FUNERAL DIRECTOR: Nicholas T. Matthews
ADDRESS: 3021 Eastern Ave., Baltimore, Md.

VS 150-REV. 1/1/65

1967000198

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-367

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1972 Registered No. 67 1972

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): George A. Peters

2. DATE AND HOUR OF DEATH: Feb. 24, 1967 | 10 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5500 Frankford Ave.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-02

D. STREET ADDRESS (If rural, give location): 5500 Frankford Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Sept. 27, 1893	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ballistic laboratory	Army	Lewistown, Pa.	U.S.A.

13. FATHER'S NAME: Michael Peters

14. MOTHER'S MAIDEN NAME: Don't know

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 1	218-09-9152	Mrs. Theresa Peters,	5500 Frankford Ave

MEDICAL CERTIFICATION

18. 332 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Thrombosis — 24 hrs.

DUE TO

(B) Arteriosclerotic Cerebro Vascular — 2 d

DUE TO Disease

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 19 60 to 2/24 19 67, that (I) (~~we~~) last saw the deceased alive on 2/22 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Paul G. Mueller M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/25/67

23C. PHYSICIAN'S NAME (Type): Paul G. Mueller M.D.

23D. ADDRESS: 6411 Belair Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	2/27/67	Cedar Hill Cemetery	Brooklyn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 28 1967	Robert E. Fahrney	Ullrich Funeral Home	4210 Belair Road.

VS 150-REV. 1/1/65

1979

P-400

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 1973

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 1973

1. NAME OF DECEASED (Type or Print): CLARENCE John PooLE

2. DATE AND HOUR OF DEATH: 2-26-67 | 2 50 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): US Public HEALth Service Hosp. 28 BALTIMORE, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: FLORDIA
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): TAMPA V-08
D. STREET ADDRESS (If rural, give location): ROUTE 6, BOX 78

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 2-25-34
9. AGE (In years last birthday): 33
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN
10B. KIND OF BUSINESS OR INDUSTRY: GLASS FACTORY
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CLARENCE PooLi
14. MOTHER'S MAIDEN NAME: HELEN WANAMAKER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records - US PHS Hospital
ADDRESS:

MEDICAL CERTIFICATION

I. 1B. 204.31

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: DAYS

DUE TO

(B) Acute Lymphocytic Leukemia — months

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 30 1967 to Feb 26 1967, that (I) (we) last saw the deceased alive on Feb 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William L Wilkie M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: 2-26-67
23C. PHYSICIAN'S NAME (Type): WILLIAM L. WILKIE M.D.
23D. ADDRESS: US PHS HOSPITAL, BALTIMORE MD

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 2/27/67
24C. NAME of CEMETERY or CREMATORY: GARDENS OF MEMORY
24D. LOCATION (City, town, or county) (State): TAMPA FLORIDA

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: ULLRICH FUNERAL HOME
ADDRESS: 4210 BELAIR

VS 150-REV. 1/1/65

K-530 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-02821 1974

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1974

1. NAME OF DECEASED (Type or Print): DONALD ORVILLE KENNEDY

2. DATE AND HOUR OF DEATH: Feb. 22, 1967 4:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 BON SECOURS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: 8-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 1655 N. MILTON AVE #13

D. STREET ADDRESS (If rural, give location): Balto Md

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): none

8. DATE OF BIRTH: 2-7-67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 15 If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: JAMES EARL KENNEDY

14. MOTHER'S MAIDEN NAME: VIRGINIA HARGROVE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MOTHER ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 773.5

(A) Hyaline membrane disease — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity (1250 gm)

19A. DATE OF OPERATION: 2/

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2-7-67 19 to 2-27 19 67, that (I) (we) last saw the deceased alive on 2-22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Aleyde A. Melocoton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/27/67

23C. PHYSICIAN'S NAME (Type): ALEYDE A. MELOCOTON M.D.

23D. ADDRESS: BON SECOURS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY: St Peters Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. [illegible]

25C. FUNERAL DIRECTOR: Thomas J. Kenny Inc

ADDRESS: Baltimore MD

VS 150-REV. 1/1/65

48-76-86 1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-600 67 1975

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1975

1. NAME OF DECEASED (Type or Print): LEO PERRY

2. DATE AND HOUR OF DEATH: 10 05 PM 2-26-67 | 10 05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1340 N. WASHINGTON ST. #21213

8-07

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 8-31-1912
9. AGE (In years last birthday): 54
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker
10B. KIND OF BUSINESS OR INDUSTRY: Steel
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANK
14. MOTHER'S MAIDEN NAME: LELA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 248-03-2242
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE #21224 ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — 30 min.

DUE TO

(B) HYPERTENSIVE CARDIOVASCULAR DISEASE — 6 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-24 1967 to 2-26 1967, that (I) ~~(we)~~ last saw the deceased alive on 2-26 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Carlos R. Hamilton Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-26-67
23C. PHYSICIAN'S NAME (Type): DR. CARLOS R. HAMILTON, JR M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE-BALTIMORE, MD 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-2-67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Marshall W. Jones, Jr.
ADDRESS: 1735 Harford Ave.

VS 150-REV. 1/1/65

F-624

BIRTH NO. 67 1976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1976

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LILLIAN R. FRESHLINE

2. DATE AND HOUR OF DEATH: FEB. 23, 1967 | 3 57 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 603 McKEWIN AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO 9-03
D. STREET ADDRESS (If rural, give location): 603 McKEWIN AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	FEB. 14, 1908	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TELEPHONE OPERATOR	C + P TELEPHONE CO OF MD.	CALVERT CO., MD	U.S.A.

13. FATHER'S NAME: COLUMBUS COCHRAN

14. MOTHER'S MAIDEN NAME: HELEN GREISON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	–	216-22-4858	FAMILY	SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
	(A) Leukemia; DUE TO	6 mth.
	(B) DUE TO	
	ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) leukemia of the cervix	4 years.
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, ~~street~~ office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this~~ hospital) attended the deceased from JAN 17 1966 to Feb 22 1967, that (I) (~~we~~) last saw the deceased alive on Feb 22 1967 and that in (~~my~~ our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: FEB 23/67.

23C. PHYSICIAN'S NAME (Type): EDWIN STEW BERSTOUK M.D.

23D. ADDRESS: 3500 N CALVERT ST BALT MD

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2-27-67

24C. NAME of CEMETERY ~~or CREMATORY~~: NEW CATHEDRAL

24D. LOCATION (City, town, or county) (State): BALTO., Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: J. Walter Conklin

ADDRESS: 5444 BELAIR Rd.

VS 150-REV. 1/1/65

K-613

BIRTH NO. 67 1977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1977

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Katherine Kraft

2. DATE AND HOUR OF DEATH: 2/27/67 | 6:15 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23-02

D. STREET ADDRESS (If rural, give location): 15 E. West Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 1/31/1911

9. AGE (In years last birthday): 56

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin Mannian

14. MOTHER'S MAIDEN NAME: Catherine

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family - Same

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

561.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Gangrene of lg + Sm bowel — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs

DUE TO

(B) Incarcerated umbilical hernia — 3 wks incarcerated; 25 yrs hernia

DUE TO

(C) obesity - marked

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from 2/25/67 19 to 2/27/67 19, that ☒ (we) last saw the deceased alive on 2/27/67 19 and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David J. Steinbauer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/27/67

23C. PHYSICIAN'S NAME (Type): DAVID J. STEINBAUER, M.D. M.D.

23D. ADDRESS: SOUTH BALTO. GEN. HOSP. 1213 Light St.

24A. BURIAL, CREMATION, REMOVAL (Specify): B

24B. DATE: 3/ /67

24C. NAME of CEMETERY or CREMATORY: Holy Cross

24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Fo[illegible]

25C. FUNERAL DIRECTOR: McCelly - 130 E. Fort Ave.

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

DR. MUSIC SP

BIRTH NO. 67 1978

Registered No. 03 67 P 1976

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WALDO B. HARSHBERGER

2. DATE AND HOUR OF DEATH: 24 FEBRUARY 1967 | 11 25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: ALLEGANY Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): LAVALE MARYLAND 21-00
D. STREET ADDRESS (If rural, give location): "Center" Street

5. SEX: MALE

6. RACE: CAUCASIAN

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7/26/18

9. AGE (In years last birthday): 48

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HEATING CONTRACTOR

10B. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WALDO HARSHBERGER

14. MOTHER'S MAIDEN NAME: AGNES HAVNER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ~~UNK~~ NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 190-05-7753

17. INFORMANT: CHART

ADDRESS:

CAUSE OF DEATH

18. 200.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) LYMPHOSARCOMA — INTERVAL BETWEEN ONSET AND DEATH: 10 YEARS

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0 NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4 FEBRUARY 1967 to 24 FEBRUARY 1967, that (I) (we) last saw the deceased alive on 24 FEBRUARY 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Music

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 24 Feb 67

23C. PHYSICIAN'S NAME (Type): STANLEY MUSIC M.D.

23D. ADDRESS: C/O UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/27/67

24C. NAME of CEMETERY or CREMATORY: Sunset Memorial Park

24D. LOCATION (City, town, or county) (State): Cumberland, Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: R. Lee E. Jones M.D.

25C. FUNERAL DIRECTOR: Byron Kight

ADDRESS: Cumberland, Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
B-400

BIRTH NO. 67 1979

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1979

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bertha Bell (NEE-RIDOUT)

2. DATE AND HOUR PRONOUNCED DEAD: 2/23/67 9:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01

D. STREET ADDRESS (If rural, give location): 1931 W. Fairmount Ave.

5. SEX: female

6. RACE: colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH: MARCH 9, 1899

9. AGE (In years last birthday): 67

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): DENTON Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WALTER RIDOUT

14. MOTHER'S MAIDEN NAME: LAURA FAULKNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: BESSIE WASHINGTON

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

422.1

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 2/23/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 3-1-1967

23C. NAME of CEMETERY or CREMATORY: MOUNT AUBURN

23D. LOCATION (City, town, or county) (State): BALTO. Md.

24A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

24B. NAME OF REGISTRAR: Robert E. Fallaya

24C. FUNERAL DIRECTOR: I.L. BROWN & SON

ADDRESS: 123 W. MONTGOMERY ST.

VS 151-REV. 1/1/65

1967 0001986

M-324 1

BIRTH NO. 67 1980

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1980

1. NAME OF DECEASED (Type or Print): JESSE J. MITCHELL

2. DATE AND HOUR PRONOUNCED DEAD: February 26, 1967 | 5:55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-1

D. STREET ADDRESS (If rural, give location): 4008 Annellen Road

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3/18/91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Johnson Mitchell

14. MOTHER'S MAIDEN NAME: Roberta A Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 23103-1255

17. INFORMANT: Callie Mitchell

ADDRESS: 4008 Annellen Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

DATE SIGNED: 2/27/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 3/2/67

23C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

23D. LOCATION (City, town, or county) (State): Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

24B. NAME OF REGISTRAR: [signature]

24C. FUNERAL DIRECTOR: Lytlhia L. McCinnon

ADDRESS: 2300 W North Ave Balt 16 Md

VS 151-REV. 1/1/65

1967000 1987

S-350

BIRTH NO. 67 1981

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1981

1. NAME OF DECEASED (Type or Print): MORRIS STEIN

2. DATE AND HOUR OF DEATH: FEBRUARY 24, 1967 | 2:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Mt. Sinai Nursing Home, 4613 Park Heights Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-19
D. STREET ADDRESS (If rural, give location): 5737 Jonquil Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 9/15/1894
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10B. KIND OF BUSINESS OR INDUSTRY: Shop
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Aaron Bernard Stein
14. MOTHER'S MAIDEN NAME: Bertha ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-12-2701A
17. INFORMANT: Mrs. Lena Stein, 5737 Jonquil Avenue #15

MEDICAL CERTIFICATION

1B. 450.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary edema, failure — Acute
DUE TO
(B) Generalized arteriosclerosis — 15-20 yrs
DUE TO
(C) Parkinsonism — 5 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1955 to Feb 24 1967, that (I) (~~we~~) last saw the deceased alive on Feb 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Joseph C. Matchar M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2/25/67
23C. PHYSICIAN'S NAME (Type): Dr. Joseph C. Matchar M.D.
23D. ADDRESS: 6821 Reisterstown Road

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/26/67
24C. NAME of CEMETERY or CREMATORY: (Anshe Emunah) - Aitz Chaim
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. ~~NAME OF REGISTRAR~~: [illegible]
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-325

BIRTH NO. 67 1982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1982

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH WEITZMAN

2. DATE AND HOUR OF DEATH: FEBRUARY 24, 1967 | 6:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): OO 3324 WEST GARRISON AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-18

D. STREET ADDRESS (If rural, give location): 3324 WEST GARRISON AVENUE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 9/28/1899

9. AGE (In years last birthday): 67

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF-EMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY: CLOTHING

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ABRAHAM WEITZMAN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: MRS. HELENE WEITZMAN, 3324 W. GARRISON AVENUE

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 163X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Carcinomatosis

DUE TO

(B) Carcinoma of Lungs — 2 yrs

DUE TO

(C) Carcinoma of Lung

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

—

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1967 19 to 2/24 19 67, that (I) (we) last saw the deceased alive on 2/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: R. S. Kallins M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/25/67

23C. PHYSICIAN'S NAME (Type): DR. EDWARD S. KALLINS M.D.

23D. ADDRESS: 4300 LIBERTY HEIGHTS AVENUE

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 2/26/1967

24C. NAME of CEMETERY or CREMATORY: BNAI ISRAEL

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Barlow M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.

ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

967000 1982

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-532

BIRTH NO. 67 1983

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1983

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): AMIEL F. MONTGOMERY, JR.

2. DATE AND HOUR OF DEATH: 2/25/67 5:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVNUE BALTIMORE 29, MD.

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE ZONE #27 53-00

D. STREET ADDRESS (If rural, give location): 3717 CENTURY AVENUE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: 7-5-47

9. AGE (In years last birthday): 19

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WAREHOUSEMAN

10B. KIND OF BUSINESS OR INDUSTRY: B. GREEN CO.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AMIEL F. MONTGOMERY, SR.

14. MOTHER'S MAIDEN NAME: DOROTHY CROWTHER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN ----- No

16. SOCIAL SECURITY NO.: 216-48-9024

17. INFORMANT: ST.AGNES HOSPITAL, WILKENS & CATON AVE.

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 204.31

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Leukemia, acute, monomyelocytic

DUE TO

(B) Pneumonia, both lower lobes

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-26 19 67 to 2-25 19 67, that (I) (we) last saw the deceased alive on 2-25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Korbuly M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Feb. 25, 1967

23C. PHYSICIAN'S NAME (Type): S. KORBULY M.D.

23D. ADDRESS: ST.AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Feb. 28, 1967

24C. NAME of CEMETERY or CREMATORY: Glen Haven Mem. Park

24D. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Kahn M.D.

25C. FUNERAL DIRECTOR: Eugene B. Fleming

ADDRESS: Singleton Funeral Home Glen Burnie, Md

VS 150-REV. 1/1/65

B-612

BIRTH NO. 67 1984

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1984

1. NAME OF DECEASED (Type or Print): BROBECK, CARL SIBLY

2. DATE AND HOUR OF DEATH: FEBRUARY 24, 1967 | 5:10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: A.A. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ANNAPOLIS JUNCTION

52-00

D. STREET ADDRESS (If rural, give location): P.O. BOX 66

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced (specify))	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	9/5/81	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	FARMER	TEXAS	U S A

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 411 84 8634

17. INFORMANT: HOSPITAL SLIP-ST. AGNES HOSPITAL

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia LLLobe

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) X (this hospital) attended the deceased from FEBRUARY 11, 19 67 to FEBRUARY 24, 19 67, that (I) X (we) last saw the deceased alive on FEBRUARY 24, 19 67 and that in (my) XX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXX (did not) view the body after death.

23A. SIGNATURE: George S. Patrick M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/24/67

23C. PHYSICIAN'S NAME (Type): GEORGE S. PATRICK M.D.

23D. ADDRESS: ST. AGNES HOSPITAL-CATON & WILKENS AVES. BALTO., MD. 21229

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3/27/1967

24C. NAME of CEMETERY or CREMATORY: Pagersville Cemetery

24D. LOCATION (City, town, or county) (State): Pagersville Tenn.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Wilbert Anderson

ADDRESS: Laurel Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1985 Registered No. 67 1985

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARIANNA ALVANO

2. DATE AND HOUR OF DEATH: 2-24-67 11 45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bolton Nursing & Conv. Center 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Md. 21213
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03
D. STREET ADDRESS (If rural, give location): 3613 Ravenwood Avenue

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 10/26/75
9. AGE (In years last birthday): 91
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Guseppi Salamone
14. MOTHER'S MAIDEN NAME: Louisa Colaiani

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-52-0764J1
17. INFORMANT: Louis Alvano, son, above
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

I 1B. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2-5-61 to 2-24-67 40 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Brain contusion

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-5 1965 to 2-24 1967, that (I) (we) last saw the deceased alive on 2-24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sebastian Russo M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2-25-67
23C. PHYSICIAN'S NAME (Type): SEBASTIAN RUSSO M.D.
23D. ADDRESS: 5017 HARFORD ROAD

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2/28/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Graham M.D.
25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-2001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1986 Registered No. 67 1986

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANCES A. HAAS

2. DATE AND HOUR OF DEATH: 2/27/67 2 15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 21213
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03
D. STREET ADDRESS (If rural, give location): 4008 Ardley Ave.

5. SEX: F
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 10/28/99
9. AGE (In years last birthday): 67
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Abingdon Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Babka
14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 216-46-2159
17. INFORMANT: Timonium, Md. ADDRESS: Mary K. Dempsey, dght. 108 Ardoon Rd.

MEDICAL CERTIFICATION

18. 18.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Gram negative sepsis — 8 days

DUE TO

(C) Carcinoma of the bladder — about 1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/14/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of bladder
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 2/6 1967 to 2/27 1967, that ~~(I)~~ (we) last saw the deceased alive on 2/27 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Stephen P. Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/27/67
23C. PHYSICIAN'S NAME (Type): STEPHEN P. COHEN M.D.
23D. ADDRESS: Sinai Hospital of Bladder

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/2/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Lafferty, M.D.
25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

45-66-97
IW

1 M-420 67 1987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1987

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Stanley Marion Mleczko

2. DATE AND HOUR OF DEATH: 2-26-67 - 5 am M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: BALTIMORE City Hospital
(If not in hospital or institution, give street address or location): 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore. 26-03
D. STREET ADDRESS (If rural, give location): 4115 BRENDAN AVENUE - 21213

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: 7-25-56
9. AGE (In years last birthday): 10
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND, BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARION MLECZKO
14. MOTHER'S MAIDEN NAME: JUSTINE POPOWSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224
ADDRESS:

MEDICAL CERTIFICATION

18. 237X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Brain tumor - Posterior fossa
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/28 19 66 to 2/26 19 67, that (I) (we) last saw the deceased alive on 6/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Carlos Uriarte M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: 2/26/67
23C. PHYSICIAN'S NAME (Type): Carlos Uriarte M.D.
23D. ADDRESS: BALTIMORE City Hospital 4940 Eastern Avenue Balto., Md. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/2/67
24C. NAME of CEMETERY or CREMATORY: Sacred Heart Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Sachs
25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1988 Registered No. 34-98-86 67 1988

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Powell, Daniel Cameron

2. DATE AND HOUR OF DEATH: 2/26/67 3 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital 33rd & Calvert Sts. Balto. 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 21213
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2842 Lake Av.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): never married
8. DATE OF BIRTH: 1-14-07
9. AGE (In years last birthday): 60
(If Under 1 Yr. Months, Days; If Under 24 Hrs. Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bethlehem Steel Corp. Sparrows point, Md.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry J. Powell
14. MOTHER'S MAIDEN NAME: Catherine ~~Xxxxxxx~~ Saunders
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (Brother in law) ADDRESS: Mr. Herbert Wilhelm. 2840 Lake AV. Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia
DUE TO
(B) Bronchogenic Carcinoma
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

162.1

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/9/1967 19 to Feb. 26 19 67, that (I) (we) last saw the deceased alive on Feb. 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang-Kyun Shin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): SANG-KYUN SHIN
William H. Renner M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3/2/67
24C. NAME of CEMETERY or CREMATORY: Balto. Nat. Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-362

67 1989

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 1989

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): (Alease) Alesa Southers

2. DATE AND HOUR PRONOUNCED DEAD: 2/24/67 10:55 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Lutheran Hospital

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

15-04

D. STREET ADDRESS (If rural, give location): 1702 W. North Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	colored	Single	10-31-1905	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Forrest, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Allen

14. MOTHER'S MAIDEN NAME: Bessie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Aaron Allen ADDRESS: 2214 Whittier Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic and hypertensive cardio-vascular disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Partial

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy X and that on this basis, death in my opinion resulted from: Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

Partial

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER X
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: 2/24/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 2-28-67

23C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

23D. LOCATION (City, town, or county) (State): Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

24B. NAME OF REGISTRAR: Robert E. Fairbanks

24C. FUNERAL DIRECTOR: Morton & Dyett F.H.

ADDRESS: 1701 Laurens St.

VS 151-REV. 1/1/65

1967000199 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1990 Registered No. 67 1990

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Respass, Harry Lee, Sr.

2. DATE AND HOUR OF DEATH: 2-25-67, 2 10 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 4-02

D. STREET ADDRESS (If rural, give location): 734 W Fayette St

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 10-1-14

9. AGE (In years last birthday): 52

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): truck driver

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfonso Respass

14. MOTHER'S MAIDEN NAME: Crandell (Louie)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 240-03-8410

17. INFORMANT: Wife ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 199.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Metastasis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/25 1967 to 2/25 1967, that (I) (we) last saw the deceased alive on 2/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A Skrigkus M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2-25-67

23C. PHYSICIAN'S NAME (Type): A. Skrigkus M.D.

23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 3-1-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State): Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney M.D.

25C. FUNERAL DIRECTOR: Morton & Dyett F.H. ADDRESS: 1701 Laurens St

VS 150-REV. 1/1/65

1967 0 0 1 9 9 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released by M.E. 558 Am 3-25-67

R-12

A-652

BIRTH NO. 67 1991

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 25 68 58 ARMSTRONG, JOHN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JOHN W. ARMSTRONG JR.

2. DATE AND HOUR OF DEATH: 2/26/67 3:50 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-10
D. STREET ADDRESS (If rural, give location): 4903 ST. GEORGE'S AVENUE

5. SEX: MALE
6. RACE: COLORED
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPARATED
8. DATE OF BIRTH: 3-5-30
9. AGE (In years last birthday): 36
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W ARMSTRONG SR.
14. MOTHER'S MAIDEN NAME: ELIZABETH FORREST

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. John Armstrong, Sr. 4903 St. George — ADDRESS:

MEDICAL CERTIFICATION

18. 330X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pseudomonas pneumonia
DUE TO
(B) Aspiration
DUE TO
(C) Subarachnoid hemorrhage

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 1 1967 to Feb. 26 1967, that (I) (we) last saw the deceased alive on Feb 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F. Ismail Beigi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/26/67
23C. PHYSICIAN'S NAME (Type): F. ISMAIL BEIGI M.D.
23D. ADDRESS: JHH.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-2-67
24C. NAME of CEMETERY or CREMATORY: Balto. National Cem.
24D. LOCATION (City, town, or county) (State): Balto., Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Fabian
25C. FUNERAL DIRECTOR: Morton & Dorett F.H. — ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

6-536 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1992 Registered No. 67 1992

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gonderman, Isabelle (Mrs.)

2. DATE AND HOUR OF DEATH: 2-27-'67 | 9:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Montebello State Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

8844 Satyr Hill Road Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore County 53-00

D. STREET ADDRESS (If rural, give location): 8844 Satyr Hill Road

5. SEX	6. RACE	7. MARITAL STATUS (Never Married, Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Widowed	XX-4-11-79	87				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Bennett	Liza Cloud

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		220-48-4146	Mrs. Thelma Griffin	8844 Satyr Hill Rd. 21234

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease with congestive

DUE TO

(B) heart failure

DUE TO

(C) Pulmonary Infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis generalized

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-9- 1967 to 2-27- 1967, that (I) (we) last saw the deceased alive on 2-27- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Hea Lew M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2-27-67

23C. PHYSICIAN'S NAME (Type): Young, Hea Lew M.D.

23D. ADDRESS: Montebello State Hosp. Balt. MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	3/2/67	Lorriane Park Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
FEB 28 1967	Robert E. Fahey M.D.	Wm. Cook-Brooks Towson	1050 York Rd. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-2-5 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1993 Registered No. 67 1993

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Grace Mason

2. DATE AND HOUR OF DEATH: 2-24-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 801 Brooks Lane

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-01

D. STREET ADDRESS (If rural, give location): 801 Brooks Lane

5. SEX: Female

6. RACE: Negroid

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 1-26-89

9. AGE (In years last birthday): 78

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Harris

14. MOTHER'S MAIDEN NAME: Alice Boom

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Oscar Mason ADDRESS: 801 Brooks Lane-Husband

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 331 IX

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — 2 weeks

DUE TO due to Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/13 1967 to 2/24 1967, that (I) (we) last saw the deceased alive on 2/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ralph W. Reckling M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/27/67

23C. PHYSICIAN'S NAME (Type): Ralph W. Reckling M.D.

23D. ADDRESS: 1401 A Edmondson Avenue

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-28-67

24C. NAME of CEMETERY or CREMATORY: Balto. Nat'l. Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Taylor, MD

25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348N. Calhoun St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1994 Registered No. 67 1994

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Jolley, Sherman

2. DATE AND HOUR OF DEATH: 2-26-67 | 2:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc. Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY: Maryland
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 552 Robert Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 12-18-02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Georgianna

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 218103006
17. INFORMANT: Dorothy Jolley (Wife) ADDRESS: 552 Robert Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — 331 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CVA

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-24-67 19 to 2-26-67 19, that (I) (we) last saw the deceased alive on 2-26-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A Khaliq M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2-27-67
23C. PHYSICIAN'S NAME (Type): Dr. Khaliq M.D.
23D. ADDRESS: 1514 Division Street

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-2-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. [illegible]
25C. FUNERAL DIRECTOR: Kelson Funeral Home
ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5/ G 10663

BIRTH NO. 67 1995

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1995

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Eclouise ~~Gearhardt~~ Gerhardt

2. DATE AND HOUR OF DEATH: February 25, 1967 | 12 00 Midnight A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital 48 Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore - 21215 15-10
D. STREET ADDRESS (If rural, give location): 3804 Ridgewood Ave.

5. SEX: F
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10-13-08
9. AGE (In years last birthday): 58
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ~~Germany~~ Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Reitz
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-28-2378
17. INFORMANT: Mr. Edwin Gerhardt
ADDRESS: 3804 Ridgewood Ave. - 21215

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

331 X

(A) respiratory failure
DUE TO
(B) intra-cerebral hemorrhage — 6 days
DUE TO
(C) hypertensive vascular disease — 20 years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: obesity, (marked)

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/16 1967 to 2/25 1967, that (I) (we) last saw the deceased alive on 2/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/25/67
23C. PHYSICIAN'S NAME (Type) M.D.:
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-1-67
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Fairbanks
25C. FUNERAL DIRECTOR: Witzke F.D.-4101 Edmondson Ave.
ADDRESS:

VS 150-REV. 1/1/65

0 2 0 0 2

12/ B1-B52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1996 Registered No. 67 1996

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Boettinger, Saville J.

2. DATE AND HOUR OF DEATH: Feb 24, 1967 7:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Montebello State Hospital Balto Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 27 53-00

D. STREET ADDRESS (If rural, give location): 1950 Victory Drive

5. SEX: F 6. RACE: Can 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH: 5-25-04 9. AGE (In years last birthday): 62 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country): Balto Md. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W 14. MOTHER'S MAIDEN NAME: Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 219-18-5615 17. INFORMANT: Chas T ADDRESS: Mr. Joseph Boettinger 1950 Victory Drive - 21227

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

(A) Acute Myocardial Infarction — 8 days

DUE TO

(B) Arteriosclerotic Heart Disease ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1/30 1967 to 2/24 1967, that ~~(I)~~ (we) last saw the deceased alive on 2/24 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Donald T Lewers MD M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 2/24/67

23C. PHYSICIAN'S NAME (Print): Donald T Lewers M.D. M.D. 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 2-28-67 24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem. 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 25B. NAME OF REGISTRAR: Louis E. Gouldman, M.D. 25C. FUNERAL DIRECTOR: Witzke F.D. - 4101 Edmondson Ave. ADDRESS

VS 150-REV. 1/1/65

1 9 6 7 0 0 0 2 0 0 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

25 67 1997

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 1997

1. NAME OF DECEASED (Type or Print): IRA A. JOHNSON

2. DATE AND HOUR OF DEATH: 2/27/67 | 5:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALT. CITY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALT CITY

D. STREET ADDRESS (If rural, give location): 1618 E. FEDERAL ST

S-06

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3/16/11

9. AGE (In years last birthday): 55

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Johnson

14. MOTHER'S MAIDEN NAME: WOOLFORD, Georgia

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-09-9171

17. INFORMANT: CHART

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) METASTATIC ADENO CARCINOMA OF STOMACH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: 1 1/4 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 1965 to Jan 1967, that (I) (we) last saw the deceased alive on 1/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Allen Ginsberg M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 2/27/67

23C. PHYSICIAN'S NAME (Type): ALLEN GINSBERG M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried

24B. DATE: 3-2-67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Fuller M.D.

25C. FUNERAL DIRECTOR: Elroy O. Wilson and Brandyth

ADDRESS:

VS 150-REV. 1/1/65

Released Thru Med. to Dr. Crogan M.E. J.H.N.

Johnson Ira 4398 94

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
L-200

67 1998

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 1998

1. NAME OF DECEASED (Type or Print): Marcell U S LEWIS

2. DATE AND HOUR PRONOUNCED DEAD: February 25, 1967 11:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33/99 Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-04

D. STREET ADDRESS (If rural, give location): 1030 N. Wolfe Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 8-25-1948

9. AGE (In years last birthday): 18

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Middle Sylvania Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Salmon Lewis

14. MOTHER'S MAIDEN NAME: Mary Boolte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Solman Lewis ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E981X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of chest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): tavern

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1111 North Gay 8-07

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-25-67 10:45 P.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Shot by assailant

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: February 26, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 3-3-67

23C. NAME of CEMETERY or CREMATORY: Metropolitan Cat

23D. LOCATION (City, town, or county) (State): Lanview, Essex Co, Va

24A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

24B. NAME OF REGISTRAR: Robert E. Fahey M.D.

24C. FUNERAL DIRECTOR: K. White Harris Funeral Home ADDRESS: Lanview, Essex Co, U.A.

VS 151-REV. 1/1/65

N8 7 2 4 7 0 0 0 2 0 0 5

D-241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 1999 Registered No. 67 1999

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DOUGLAS, HELEN

2. DATE AND HOUR OF DEATH: 2-26-1967 | 5:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-01
D. STREET ADDRESS (If rural, give location): 2017 W. LEXINGTON ST.

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 1-9-20
9. AGE (In years last birthday): 47
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjman Thomas
14. MOTHER'S MAIDEN NAME: Bertdette Monroe

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Douglas
ADDRESS: Same

MEDICAL CERTIFICATION

18. 5927 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) NEPHROTIC SYNDROME
DUE TO
(B) CHRONIC NEPHRITIS
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN. 30 1967 to FEB. 26 1967, that (I) (we) last saw the deceased alive on FEB. 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Kil Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/26/67
23C. PHYSICIAN'S NAME (Type): YOUNG KIL KIM M.D.
23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 3-2-67
24C. NAME of CEMETERY or CREMATORY: Arlington Park
24D. LOCATION (City, town, or county) (State): Md

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967
25B. NAME OF REGISTRAR: Robert E. Jackson
25C. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1060 Brantley Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BIRTH NO. 67 2000

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 2000

1. NAME OF DECEASED (Type or Print): MARY S. POLLARD

2. DATE AND HOUR OF DEATH: 2-23-67 4:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 8-06

D. STREET ADDRESS (If rural, give location): 1509 N. BETHEL ST

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 09-01-04

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Calvert County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ERNEST RANDALL

14. MOTHER'S MAIDEN NAME: DORCUS COOK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Fydella Dunmore ADDRESS: Same

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial infarction — 1 hour

DUE TO

(B) ASCVD

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GI Bleeding

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/15/67 19 to 2/23/67 19, that (I) (we) last saw the deceased alive on 2/23/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John A. Sergent M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 2/23/67

23C. PHYSICIAN'S NAME (Type): JOHN A. SERGENT M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 2-27-67

24C. NAME of CEMETERY or CREMATORY: Friendship Cem.

24D. LOCATION (City, town, or county) (State): Arundel Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: FEB 28 1967

25B. NAME OF REGISTRAR: Robert E. Tarbey M.D.

25C. FUNERAL DIRECTOR: Edward O. Wilson ADDRESS: 1000 Brantley Ave.

VS 150-REV. 1/1/65

2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.